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LACK OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES

FIELD HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

WILKES-BARRE, PA
JUNE 30, 1988

(Part 1 of 2)

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LACK OF HEALTH INSURANCE COVERAGE IN THE UNITED STATES

THURSDAY, JUNE 30, 1988

U.S. SENATE,
COMMITTEE ON FINANCE,
Wilkes-Barre, PA.

The hearing was convened, pursuant to notice, at 9:02 a.m. in the Wilkes College Performing Arts Center, South and South River Streets, Wilkes-Barre, PA, the Honorable John Heinz presiding.

Present: Senator Heinz.

[The press release announcing the hearing follows:]

[Press Release No. H-25]

FINANCE SUBCOMMITTEE ON HEALTH TO HOLD HEARING ON THE UNINSURED

WASHINGTON, DC.—Senator George Mitchell (D., Maine), Chairman of the Senate Finance Subcommittee on Health, announced Thursday that the Subcommittee will hold a field hearing on the problems resulting from the lack of health insurance coverage in the U.S. An estimated 37 million Americans lack health insurance coverage.

The hearing is scheduled for *Thursday, June 30, 1988 at 9:00 a.m.* in the Wilkes College Performing Arts Center, South and South River Streets, Wilkes-Barre, Pennsylvania. The hearing will be chaired by Senator John Heinz (R-Pennsylvania), a member of the Subcommittee on Health.

Mitchell said, "Many people in our country are without health insurance. Many pregnant women are not getting sufficient prenatal care, and many children are lacking necessary preventive care. As a society, we have a responsibility to address this serious problem."

Heinz said, "The State of Pennsylvania has initiated a number of creative programs to expand health insurance coverage, and is in the process of developing a comprehensive plan to address the problems of the uninsured. This plan is set to go to the State's General Assembly for legislative action later this year. I am interested in understanding the approaches Pennsylvania has successfully employed as well as learning more about the reasons why, despite the creative programs already in place, one million Pennsylvanians remain uninsured."

Witnesses for this hearing will appear by invitation only.

Written statements: Those who are not scheduled to make oral presentations, but who wish to present their views to the Finance Subcommittee, are urged to prepare written statements for submission and inclusion in the printed record of the hearing. These written statements should be typewritten, not more than ten (10) pages in length, and mailed with five (5) copies to Laura Wilcox, Hearing Administrator, Senate Finance Committee, SD-205, Washington, D.C. 20510 and five (5) copies to Ed Mihalski, Minority Chief of Staff, SH-203, Washington, D.C. 20510. Written statements for the record must be received *no later than Thursday, July 28, 1988.*

OPENING STATEMENT OF HON. JOHN HEINZ, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Senator HEINZ. Ladies and gentlemen, good morning.

This is a hearing of the Senate Committee on Finance of the U.S. Senate, and our subject, of course, is health insurance coverage for the uncovered, and why, in this land of plenty where some 202 million Americans do have health insurance to protect them against the unanticipated costs of illness or injury, there are still 37 million Americans who do not.

These American families without health insurance stand, like Damocles, under a sword of fear and financial disaster. And for the uninsured, for example, $60 for an office visit, or $40 for a lab test can be a very real deterrent to care.

When you think of the possibility of a $54,000 bill for a caesarean section delivery and neo-natal care for a premature baby, that is a financial catastrophe.

As medical care costs rise at double the rate of inflation, the uninsured find the cost of coverage increasingly prohibitive and the risk of exposure increasingly disastrous.

Now, we have built in this country what is often called the greatest health care system in the world. Yet, millions of the uninsured get substandard care or no care at all. Too often the first procedure in the emergency room is the "wallet biopsy," which can result in delayed or even denied necessary surgical care.

The lack of care is a particular threat for our children. For the 14 million who do not have health insurance, routine office visits, vaccinations and treatment for minor injuries become a luxury that their families must struggle to provide—14 million children.

The lack of health insurance coverage also creates a growing financial burden for hospitals and other health care providers. Each year more than $7 billion in hospital bills go unpaid. Some hospitals have to write off as much as $1 for every $8 they charge, which they need to stay in business. These growing losses make it harder for willing hospitals to provide care to the uncovered and cause others to turn the uninsured away or cut back on emergency room and other services.

This hearing marks the first time in the 100th session of Congress—this year and last—that the Senate Committee on Finance has looked into the problems associated with the lack of health insurance, and we are the major committee dealing with health care insurance.

I am very pleased that the Finance Committee has authorized this hearing, to permit me on behalf of all of the members of the committee to come here to Pennsylvania, in particular because this State has done a good deal than most others to make health care available to its citizens.

Pennsylvania's employers have traditionally provided comprehensive coverage for workers and their families. Open enrollment policies are available to individuals year-round, for the most part. and the Pennsylvania Medical Assistance Program provides coverage to individuals with high medical costs under its medically needy standard as well as more traditional Medicaid coverage to the poor.

Yet, even with all of this, more than 1 million Pennsylvanians—actually 1,200,000 Pennsylvanians, and of them, 345,000 are children—do not have any protection against their health care costs.

The State has set up a Health Care Cost Containment Council—we will hear from them today—to develop proposals to expand health insurance to our uninsured, and I am hopeful that the testimony they present will give some guidance to us at the national level as we tackle these same issues.

Today we will hear from families to have faced difficulty in getting care, from providers, from the insurance industry, and from the business community.

Our first panel will discuss why, even though health insurance plans are available, 1.2 million Pennsylvanians are still uninsured, what consequences this holds for their health, and the financial burdens the cost of care place on hospitals.

The second panel will discuss some of the options that are available for expanding coverage, and the political and economical difficulties inherent in some of these approaches.

May I say, I hope that this hearing can help us in the Senate and in the Finance Committee to develop the right approaches, the right mechanisms, to enable everybody to get the medical services that they need, with reasonable payments to health care providers and equitable sharing of health care costs.

Today I am releasing a report by the Congressional Research Service, and one prepared by the staffs of the Senate Committee on Aging and the Education and Labor Committees, which lay out the extent of the problem of the uninsured and the range of options. If you want any background information on this problem, it is probably somewhere in one of these two documents.

What those documents do, in sum, in addition to providing information is to also lay out the range of options available for expanding coverage. And in our working paper, the smaller of the two, it is information that has been compiled as a result of an ongoing working group which, as chairman and ranking member of the Committee on Aging, I began over a year ago with members of the business community, labor unions, the insurance industry, and health policy experts.

So I am pleased to be releasing today the first part of the CRS study, as well as our own.

May I say, with respect to the CRS study—as I say, this is the first part of it—that the additional parts of it will examine the implications of the various proposals, and there are numerous ones, to expand health care coverage.

I would like to thank all of the witnesses who are present today who have agreed to be here, and I look forward to their testimony.

And of course our first group of witnesses is at the table. They are Joan McNaney from Chalfont, George Siles from Wilkes-Barre, Jim Redmond from the Hospital Association, Dr. Charles Wolferth, who is with the Clinical-Surgical Association in Philadelphia, and Dr. Richard LaFleur of the Freeland Health Center in Freeland, PA.

Mrs. McNaney and gentlemen, I thank you all for being here, and I would like Mrs. McNaney to please begin.

[The prepared statement of Senator Heinz and a background paper on health coverage appear in the appendix.]

STATEMENT OF JOAN McNANEY, CHALFONT, PA

Mrs. McNaney. Good morning.

My name is Joan McNaney. I live in Bucks County, PA, with my husband and three children. My husband works on his father's farm. He does not have health insurance coverage there.

I have looked into different insurance companies over the years, but few will take individuals; and, since my husband is one of only two employees, we could not get a group insurance such as an HMO.

We have always had health insurance, but in 1984, when our premiums were $2,600 a year, more than 10 percent of our income, we decided we had to change companies. In 1985 and 1986 our premiums were $1,172, which was much more manageable on my husband's salary.

We thought we were getting adequate coverage, but we found after reading the fine print that they paid a maximum of $5,000 for each hospital stay and only part of the doctor bills. We discovered this while our oldest son was in the hospital for emergency brain surgery.

The 8-day hospital stay cost $15,549. The insurance company paid $5,000, leaving us with a balance of over $10,000 and doctor bills amounting to over $7,000.

We have worked out an agreement with the hospital to pay $200 a month toward the balance. There are some months that it is just impossible to send them $200, but they always send us a reminder.

We again went looking for a good affordable plan but ended up back with the first company. However, we still had to have a plan with our previous company on two of our children, because the new company will not cover any pre-existing illnesses for the first year of the policy.

Our insurance premiums for 1987 were $3,000 and will be again this year. This is still more than 10 percent of our yearly income. In addition to these premiums, we still must pay for our doctor and dental visits, prescriptions, and therapies, which total over $2,500 a year.

It doesn't seem fair that farmers, small business people, and the like can hardly afford the rates that the insurance companies charge. But on the other hand, if they don't have the insurance, or don't have good insurance, they could end up paying for the rest of their lives for just one hospital stay.

[Mrs. McNaney's written statement appears in the Appendix.]

Senator HEINZ. Mrs. McNaney, thank you very much. I will have some questions for you. Just to clarify one thing, though, right now you are paying $3,000 a year for health insurance?

Mrs. McNANEY. That's right.

Senator HEINZ. Plus about $2,500 out of pocket, and that is all in addition to the $200 a month, if you can make it, that you still owe the hospital, St. Christopher's, is that right?

Mrs. McNANEY. That is correct, yes.

Senator HEINZ. Which totals something like nearly $8,000 just on health costs?

Mrs. McNANEY. Right.

Senator HEINZ. All right. Thank you very much.

Mr. Siles?

STATEMENT OF GEORGE SILES, WILKES-BARRE, PA

Mr. SILES. Senator Heinz, my remarks are similar to Mrs. McNaney's, except that our experience is shorter termed. However, I can see that we may be heading in the same direction in terms of debt.

I have been through some difficult experiences in the last few years with health problems. My health made me unable to work for several years. I left a situation where I always had had excellent health coverage, at no cost to me whatsoever. As a result of a broken career because of the health problems, I found it necessary to begin a new career at an entry level position without any health insurance; my employer is unable to provide that. In 6 months, under these circumstances, the debts are increasing very rapidly.

We looked for health insurance before we began. We left the Pennsylvania Medical Assistance Program, in which we were provided coverage. At that point it was a very difficult decision. The decision was whether to work and lose the Pennsylvania Medical Assistance which had provided such excellent coverage, or to begin employment, do something productive and not have any health insurance.

We were unable to find health insurance that we could afford, after the costs of shelter, food, clothing, and other basic necessities. So, we gambled that within our very restricted and tight budget we would be able to put aside enough money on a weekly basis to provide for visits to doctors and that sort of thing. It hasn't worked. It just isn't working.

Six months into a new career, in an attempt to begin a new life, we find that we are faced with the kind of dilemma that I hope very few people have to face, which is to stop working and go back to medical assistance, or to continue and go further and further in debt.

My family is 4 of those 1,200,000 Pennsylvanians that you were talking about, and it is very stressful on a daily basis to deal with this.

I have been through all kinds of health coverage through my lifetime—full health coverage, partial health coverage. But this is the only time I have been without it. Believe me, it is not a very desirable situation.

Senator HEINZ. You say you tried to get health insurance.

Mr. SILES. Yes.

Senator HEINZ. What was the lowest priced policy you were able to find?

Mr. SILES. Well, again, it is somewhat similar to Ms. McNaney's experience. Either there were exclusions, which made it impossible for me to be covered because of my past medical history, or because my wife was pregnant at the time, or because our new baby was going to be born—so there were either stipulations which excluded us, or the costs were prohibitive.

The Blue Cross, which we intended to join initially, seemed feasible. Just at the time we were going to enroll, their rates went up, and they went beyond what our budget could allow.

Senator HEINZ. Which was how much?

Mr. SILES. I think it was something like two and a half weeks' salary per month for me, which was too much.

Senator HEINZ. Two and a half weeks' salary per month?

Mr. SILES. Per month, yes, to cover us for 3 months. In other words, I would have to work 2½ weeks.

Senator HEINZ. For 3 months coverage?

Mr. SILES. Yes.

Senator HEINZ. OK.

Mr. SILES. And we felt we couldn't do it. There were too many dislocations going on in the family at that time to handle that kind of thing.

Senator HEINZ. All right.

Mr. SILES. We looked into others, and again there were stipulations which excluded one or the other of us, and we felt we couldn't do it.

Senator HEINZ. Mr. Siles, thank you. I will have some more questions for you.

Mr. SILES. All right.

[Mr. Siles' prepared statement appears in the appendix.]

Senator HEINZ. Mr. Redmond?

STATEMENT OF JIM REDMOND, HOSPITAL ASSOCIATION OF PENNSYLVANIA, HARRISBURG, PA

Mr. REDMOND. Thank you, Senator.

Mrs. McNaney and Mr. Siles are two examples, as you mentioned, of the one million persons in Pennsylvania who do not have any public or private health insurance.

You made reference in your opening remarks to the Pennsylvania Health Care Cost Containment Council's study which was recently released, and you will hear later from Ernie Sessa about the efforts of the Health Care Cost Containment Council, but I thought I would try to summarize briefly some of the more significant findings in that study, because I think they lead us to some obvious solutions that we hope we can implement here in Pennsylvania and perhaps across this nation.

About 8.6 percent of Pennsylvania's population have no public or private health insurance. About 70 percent of those who are uninsured have incomes below 150 percent of the Federal Poverty Level, which is about $16,800 per year for a family of four.

What is interesting about that population is that about one-half of all of the uninsured adults are employed. Over one-third of the low income uninsured are children. Rates of uninsurance vary by region. The Pittsburgh area has a rate of about 10.6 percent, when compared to the rest of the State at 8.6 percent. Philadelphia is right at the State average. Also, the uninsured have poorer health status than the insured.

Second, many employers do not offer health benefits. Well over half of the firms with fewer than five employees offer no health care coverage, and over one-third of the firms with five to nine employees offer no health care coverage. Over 90 percent of the small firms that offer insurance to full-time employees do not extend coverage to their part-time employees, and over 17 percent of small firms do not extend coverage to dependents of employees.

A third major finding is that Pennsylvania's Medical Assistance Program, or Medicaid Program, is not designed to cover all of the poor. In fact, only 50 to 60 percent of those below 150 percent of the Federal Poverty Line are covered, and only three-fourths of those eligible for Medicaid benefits are enrolled in the program.

Fourth, the medically indigent face barriers in their use of health care services. The uninsured are more likely to be without the usual source of care; the uninsured are more likely to be dependent upon hospital-based sources of care; the uninsured report difficulty in obtaining needed care; and the medically indigent tend to defer or postpone seeking health care services.

Finally, in Pennsylvania, access for the medically indigent to obtain emergency medical care or inpatient care, at least at this time, is generally and widely available.

The problem that we see over the near term is that the extent that services are available to the medically indigent depends in part upon the financial capacity and commitment of health care providers. Hospitals provide charity care to both inpatients and outpatients, and this care is primarily financed through a series of cross-subsidies from privately insured patients. It is also, to a lesser extent, supported by private philanthropy and government grants and appropriations.

We estimate that this year hospitals in Pennsylvania will provide approximately $450 million worth of care to the medically indigent, and another $170 million in care that represents payments that are less than cost under the Medical Assistance Program.

Much of the care provided to the uninsured and underinsured is in essence paid by employers and employees who are insured. This method of financing forces business to subsidize the care provided to employees of businesses which do not provide insurance.

There is a danger of erosion of the current financing system that we have here in Pennsylvania, and really across the nation, as competitive and cost-containment efforts increase.

Faced with the need to stabilize or lower prices to charge-paying patients, hospitals must either lower their operating margins or reduce their uncompensated care. Otherwise, they risk losing charge-paying patients to other facilities. Hospitals with a high volume of uncompensated care can also be at an unfair competitive advantage with their competitors who do not serve the medically indigent. In other words, access to hospital care for the medically indigent may be dramatically cut back if current cost-containment efforts continue without a recognition that there needs to be a way in which we can provide full health care coverage to all citizens of this country.

In looking at this issue, the Hospital Association of Pennsylvania recommends that State and Federal Governments should do at least three things:

First of all, maximize Medicaid coverage.

We think we need to enhance the eligibility standards to the maximum extent possible under federal law. Congress has done this recently, and we see that as a good step.

We also need to establish effective mechanisms to enroll people in Medicaid. Many people are not on the welfare rolls, are in need of health care services, are eligible under the spend-down provisions of the Medicaid Program, but simply don't know how that system works, and we need to increase our efforts to encourage people to participate in that program when illness and injury strike, and also to assist hospitals in enrolling persons into that particular program.

Senator HEINZ. Let me just ask you, at that point, I noted earlier that you said that something like only three-fourths of those eligible for Medicaid are enrolled. Are you talking about people under age 65?

Mr. REDMOND. Yes.

Senator HEINZ. What is the reason for that?

Mr. REDMOND. Well, I think it is complex. When someone gets sick, they don't go to the local Department of Public Welfare office to get their health insurance; they are in a hospital. And they need to take the necessary steps to go through the complex eligibility standards and verification process to get on Medicaid.

I think we suffer from a lack of sufficient case workers in the Medicaid Program to enroll people on a timely basis. I think we suffer from a lack of knowledge on the part of individuals about the benefits of the Medicaid Program, as Mr. Siles pointed out. That program, if you suffer severe enough medical expenses, can provide tremendous protection for individuals.

One of the problems, as Mr. Siles pointed out, though, is that when you are well enough and ready to go back to lead a productive life, you may face the problems that Mr. Siles presented, in that you will take a job that does not cover health insurance, and you face that very difficult decision, as he did, in, "Do I lose that protection?"

Senator HEINZ. I will come back to that issue.

Mr. REDMOND. OK.

Senator HEINZ. Please proceed. You were talking about the second point in your testimony.

Mr. REDMOND. Well, the third point under Medicaid is that we need to make sure that the payment rates for services approximate the cost, if we indeed expect physicians and hospitals to provide services to these individuals.

The second point is that we need to maximize the use of private health insurance by encouraging employers to provide health care coverage to their employees, dependents, and retirees; we need to create incentives, particularly for small businesses, whose cost of health care coverage for their employees is high, and we need to provide incentives for them to offer that, and perhaps ways to lower the cost of providing that coverage; third, we need to encourage the purchase of insurance by individuals who do not have employer-sponsored coverage; and, fourth, we need to make it easier for those who face a job loss and need to protect them while they are looking for another job.

Third, despite efforts in terms of expanding public and private health insurance coverage, there are going to be some targeted groups for whom we need to establish some special programs. We believe that we need to establish special programs to deal with the problems of health care services to pregnant teenagers, and the savings that can result from adequate prenatal care are tremendous when you compare that with the cost of taking care of a low-weight infant.

We also need to provide protection for our children, for migrant workers, the mentally ill, the chemically dependent, and the homeless. You will hear later from Dr. Wolferth about some of the problems in providing trauma care, where the problem of uninsurance and underinsurance particularly is a factor in the development of our trauma care networks throughout this country.

We need to make sure that primary and preventive health care services are available to these individuals, because clearly the out-of-pocket expenses associated with seeking such care deters them from seeking necessary care that can help to lower health care costs in the long run. And we believe the best way to do that is by making direct arrangements with providers who perform those services in the areas in which those persons reside.

In summary, it is not a question of knowing what to do about this particular problem; it is a question of whether we have the commitment to recognize that there are numerous people within Pennsylvania and across this Nation who do not have the protection that you and I have when health care is required, and we need to make sure that we extend our health care coverage to all, and also to recognize that the services that are currently being provided are paid for in some way through the cost subsidies offered through those that provide health care coverage to their employees and dependents.

Thank you.

Senator HEINZ. Thank you very much, Jim.

[Mr. Redmond's prepared statement appears in the appendix.]

Senator HEINZ. Dr. Wolferth?

STATEMENT OF DR. CHARLES C. WOLFERTH, M.D., PROFESSOR OF SURGERY, HAHNEMANN UNIVERSITY SCHOOL OF MEDICINE, PHILADELPHIA, PA

Dr. WOLFERTH. Senator Heinz, my name is Charles Wolferth. I am a professor of surgery at Hahnemann University School of Medicine in Philadelphia. Since 1977 I have been a member of the American College of Surgeons' Committee on Trauma. The college has had over five decades of interest in improving the care of the injured. Members of the Committee on Trauma were part of the National Research Council group that issued a white paper labeling trauma "the neglected disease of modern society" 22 years ago. A 12-year followup study of emergency medical systems was disappointingly slow. Subsequent trauma death studies have documented that one-third of the trauma deaths in non-trauma-designated hospitals were totally preventable.

Since 1976 the American College of Surgeons has developed an Optimal Resource Document which developed strict criteria for the establishment of trauma centers and trauma systems. This document has been periodically updated; the most recent Optimal Resource Document was published in the Bulletin of the American College of Surgeons in October 1986.

Last week, Dr. John West of California, Dr. Donald Trunkey of Oregon, and I published in the June 24, 1988, issue of the Journal of the American Medical Association our review of the eight essential components of regional trauma systems, based on criteria set by the American College of Surgeons. Only two States were found to have all components of State-wide trauma coverage. Nineteen States and the District of Columbia lacked one or more component of regional trauma care.

Perhaps the most important finding, Senator, in our article was the finding that 29 States have yet to initiate a process of trauma care and trauma system designation.

Some regions and cities, if not States, have been significantly ahead of the rest of the country in the designation of effective trauma care systems.

Approximately 1 year ago I completed a study which identified approximately 286 trauma centers throughout the country, with a very uneven geographic distribution. Approximately 140 of these centers have undergone some form of outside peer review; the rest are self-designated. Over half the population of the United States is not served by any formally recognized trauma-designation process or system.

On the basis of having served as a trauma site visitor in over 100 hospitals throughout the country during the past 7 years, I am aware of how delicately balanced is the process where good trauma care does exist In fact, effective trauma care is beginning to deteriorate where it previously existed in some of the longer established trauma areas, and is sure to happen in the few other more recently developed areas as well, including the State of Pennsylvania.

Two excellent examples of the precariousness of trauma care are the fact that seven of 17 designated trauma centers in Los Angeles and four of the five trauma centers in Miami have closed during the past year.

The overwhelmingly single most important factor in the closure of these trauma centers is simply the inability of these hospitals to provide for uncompensated care. Virtually all hospitals in the United States today can and do provide for a reasonable amount of uncompensated indigent care.

When a trauma center receives, by its nature, a significantly higher percentage of what would otherwise be its fair share of uncompensated care, the choice that many trauma center hospitals must make is either to drop out of the system or go bankrupt. Many are dropping out of the system.

Trauma care, by its nature, is extraordinarily expensive. But if lives are to be saved, institutions willing to make the trauma-center provision of care must be compensated fairly for indigent and uncompensated care.

Nationally, it costs approximately $13,000 per average trauma admission for hospital costs alone—no physician costs are included in that. A hospital that receives 500 uncompensated indigent trauma patients per year can expect that nonreimbursed costs for these patients alone will total $6.5 million per hospital per annum, a figure that most hospitals cannot bear.

Another excellent example of this shortfall is a Level One, the highest type of trauma center, in the District of Columbia, which provides over $6 million of trauma care for the citizens of the District of Columbia and was reimbursed 9.4 percent of these costs during fiscal 1987. Essentially, this institution provided over $5.5 million of free trauma care just to the citizens of Washington, DC, not to mention the $2 million of uncompensated care given to the citizens of Maryland, and over $1 million to the citizens of Virginia.

There are few hospitals in this country that can afford to do this over any period of time without serious disruption to other vital medical services or even its own survival.

Another area of major concern to those of us who are involved in the day-to-day provision of trauma care services is the virtual impossibility of obtaining long-term vitally needed rehabilitation services for the trauma victim who does not have comprehensive major medical insurance. These vitally needed services are not inexpensive but are a major factor in the shortfall of trauma care services, especially for the indigent and needy.

Senator Heinz, it is my firm conviction that enlightened, comprehensive Federal legislation and funded care for the trauma victims not otherwise covered must be mandated and is the only realistic solution.

Trauma kills over 140,000 and permanently disables more than 280,000 Americans each year. Each year that means that trauma kills and permanently maims two and a half times all of the victims of the 11 years of the United States involvement in Vietnam.

Trauma is the leading killer of the young and through the fourth decade of life. Because it is a killer of the young and otherwise healthy person, trauma accounts for more years lost of productive life than cancer and heart disease combined. It remains today—22 years after the National Research Council's White Paper—the neglected disease of modern society.

Senator, I appreciate the opportunity of presenting my testimony to you this morning.

Senator HEINZ. Dr. Wolferth, thank you very much.

[Dr. Wolferth's prepared statement appears in the appendix.]

Senator HEINZ. Let me just ask you one question, and I will have some other questions. You say that we ought to mandate trauma care for the "otherwise uncovered." If we were to simply make a choice in Washington, not that this would necessarily be a good choice, and the only thing that we wanted to cover would be trauma care, how would we go about mandating that?

Dr. WOLFERTH. I think that there has to be a federal mandate to stimulate the 29 States that have nothing in the United States today. I am not quite sure. I have some very definite ideas on how that can be done.

Senator HEINZ. Well, share one of them with us.

Dr. WOLFERTH. I think that a solution will have to come from the roadblocks, the local roadblocks, that are perceived by many States.

We had the same problem in Pennsylvania a number of years ago, and it was through a cooperative effort of the Hospital Association and the Medical Association and the Pennsylvania Nursing Association to develop a system.

I believe that there has to be a timetable put to the States that do not have a system. Perhaps, given a reasonable period of time, 2 to 3 years, because it takes that much to get these various provider groups to talk to one another effectively, that a system of care perhaps through Medicaid and Medicare payments, that if a system is not in place to provide improvement in care——

Senator HEINZ. You are focusing on having adequate quality of trauma care.

Dr. **Wolferth**. First there has to be a system.

Senator **Heinz**. At the same time there has to be a methodology for paying for it; because, if you don't have a mechanism for paying for it, you won't have any care at all, let alone quality care.

Dr. **Wolferth**. What is happening is that the places, the hospitals that have made a commitment anywhere between $1 million and $3 million a year to have surgeons, anesthesiologists, radiologists, and all the people that need to be in for a trauma center 24 hours a day, 7 days a week, need to be compensated fairly and reasonably, not excessively. What is happening is that those hospitals that have made that dollar commitment are getting out of the system because they are not being compensated fairly for the indigent care.

Senator **Heinz**. As you indicated in Miami and Los Angeles.

Dr. **Wolferth**. Yes, sir.

Senator **Heinz**. Very well. Thank you very much, Dr. Wolferth. Dr. LaFleur?

STATEMENT OF DR. RICHARD LaFLEUR, M.D., FREELAND HEALTH CARE CENTER, FREELAND, PA

Dr. **LaFleur**. Senator Heinz, I am Dr. Richard LaFleur. I am a public health physician for the Rural Health Corporation of Northeast Pennsylvania. I have been practicing in Freeland for approximately 2 years, and in that time I have seen a number of patients and problems that have come up simply on the basis of uninsured care.

We serve a population with total patient visits accounted for by 64 percent Medicare and 16 percent medical assistance. Only 6 percent of our visits is actually insured, and 14 percent is also totally uninsured, they present to us, unable to pay anything, or has a sliding scale fee by coming to our office.

The major problem that we see in this is that our capabilities of serving this population has become less because of the number of federal cutbacks. Specifically, in my situation, being a public health physician, there is less emphasis put on primary care public health throughout the medical schools.

In only echoing what has already been said, I think the hospitals face a strong problem in the sense of cost containment. Their abilities in the past to subsidize indigent care based on the monies afforded through insurance type care has decreased. Medicare payment under the DRG system is also causing increased problems with financing that indigent care.

From my standpoint, however, I see the patients on a primary care basis, and I see three major problems:

One is in the sense of catastrophic illness, the patient who because of finances does not obtain appropriate care, does not obtain urgent care, and lets himself go simply on the basis that he cannot afford it. That, in my experience, at least through the Rural Health, has been limited; although discussing this with physicians who have worked with the Freeland Health Center, there was a situation where a patient absolutely refused any evaluation for upper gastrointestinal problems and eventually died as a result.

The second situation which is more prevalent, which I see probably on a weekly basis, is a situation where a patient will come in and have a problem that he has neglected, one that has created some injury to him, not disabling, not catastrophic; however, it has caused more problems for him physically and also from a financial basis, because at that point in time the hospital admission becomes necessary. He will go into the hospital and, because he sees the increasing costs from his hospital stay, will actually leave before the care is completed. At that point it is either that he gets better on his own, or, again, lead into that catastrophic illness.

The third thing which I think is probably the more common and probably the most costly to these people who are uninsured is the daily preventive care basis. In those situations, the patients—we see them as either (1) not coming to the physician for their general well care or (2) neglecting it in the sense of the primary role and primary testing that we have all obtained under the insured system—simple things like mammogram, urinalysis, simple things that are low cost but should be given to each one of those patients.

In my opinion, this is one of the biggest problems that we face. Not being able to offer that primary preventive care and health education to these people. It has been neglected. I think we are trying to pay for the major catastrophes, the problems of inpatient hospitalization, and I don't know the actual statistics. But I think, in knowing and seeing it on a daily basis where a patient will come in and frankly refuse to have preventive health care screening done simply on the basis of cost—I think that really is the major problem revolving around uninsured care.

I think there is a lot that has been written, a lot of options. Frankly, at this point in time I think one of the answers that we have to try to look at is somehow to provide for these uninsured people, the indigent, in the primary care setting.

To somehow delegate some of that responsibility to the insurance companies presently is an option. As to the specifics of it, at this point I don't have any real answers.

Senator HEINZ. Very well, Dr. LaFleur. Thank you very much.

[Dr. LaFleur's written testimony appears in the Appendix.]

Senator HEINZ. I want to return to our two individuals who have been very much put in very difficult circumstances by some of the real shortcomings with our health care system.

Mrs. McNaney, you are now paying roughly $8,000 a year, when you can come up with that $8,000 a year, for your health insurance, for your out-of-pocket costs, for the bills that you still owe on. What kind of income do you have? How can you afford that kind of cost of health care?

Mrs. MCNANEY. We were able to pay some of the bills because my husband had an inheritance come just a couple of weeks after my son came out of the hospital. So, we were lucky that way.

Senator HEINZ. If you hadn't had that, what would have happened?

Mrs. MCNANEY. If we hadn't, I don't know, because we went to Medical Assistance and they said, "No, you make too much money. We won't pay any of your bills." So I'm not sure what we would have done.

Senator HEINZ. What is your income from you or your husband's work each year, roughly?

Mrs. McNANEY. Twenty-eight thousand.

Senator HEINZ. Twenty-eight thousand. That is before taxes, before the Federal Government takes Social Security and Medicare, FICA, and all of the deductions that reduce that by at least a third by the time it actually gets into your hands?

Mrs. McNANEY. Right.

Senator HEINZ. So that doesn't leave you a lot to live on.

Mrs. McNANEY. No.

Senator HEINZ. It doesn't take care of the rent, the utility bills, the food. That is a staggering burden. And at $3,000, you still find that almost again as much is still uncovered.

Mrs. McNANEY. That is correct.

Senator HEINZ. Mr. Siles, you mentioned that when you were looking around for a policy that the policies basically excluded you in part because of a pre-existing condition, and your wife, who was then pregnant.

Mr. SILES. Yes.

Senator HEINZ. Or that the cost was exorbitant.

Mr. SILES. Yes. Or there was a long waiting period in some cases. Cost is obviously one of the main factors, and in order to pay for an insurance which is going to require somebody to wait a year for inclusion is kind of double paying that goes on—the paying for the insurance, and the paying for the medical expenses relating to the pre-existing condition which needs to be treated during that year. That we didn't feel we could handle.

Senator HEINZ. Let me see if I got that right. You said that you had to wait a year for coverage but pay during the year, even though you weren't getting coverage?

Mr. SILES. Exactly. So that means a constant double——

Senator HEINZ. While you were paying for the costs of the hospitalization that you had previously suffered.

Mr. SILES. Or the care, in whatever form. The care would have to be paid for during that year in addition to the insurance premiums.

Senator HEINZ. So in effect you would be paying twice, if you could afford to pay twice.

Mr. SILES. Exactly, which on $10,400 a year we didn't feel we could afford.

Senator HEINZ. Roughly what were those costs in real dollars? What was the cost of that policy that you were talking about?

Mr. SILES. The fellow I talked to at one of the local insurance companies never quoted me a price, because when I described my salary and I described the pre-existing conditions and the kind of care that was required, he just felt that it was beyond us. So he didn't give me an exact amount; he just felt it was beyond what I was able to handle. It wasn't even a question of consideration.

Senator HEINZ. Let me ask Jim Redmond:

Mr. Redmond, you said that one-half of the uninsured adults are employed. Is Mr. Siles a fairly typical example of somebody who finds himself to be uninsurable, either because of cost or a pre-existing condition?

Mr. REDMOND. Yes, and the fact is that there are numerous healthy people out there who may have a job or two part-time jobs but do not have coverage. What is critical is that their dependents, particularly children, don't have coverage.

Senator HEINZ. Now, when people like Mrs. McNaney or Mr. Siles come into one of the hospitals in Pennsylvania, and you indicated in your testimony that the rising uncompensated care costs could force hospitals to stop providing care to the uninsured, what services are at risk? What might hospitals not provide in the future? Is it going to be the trauma care that Dr. Wolferth was talking about? Is it going to be some other kind of care? What is it going to be?

Mr. REDMOND. Well, it will be trauma care and to some degree emergency care. It will be probably prenatal care. It will also be any kind of special outpatient facilities or outreach clinics geared toward the uninsured or low-income people.

Senator HEINZ. What about maternity care?

Mr. REDMOND. Yes.

Senator HEINZ. That would be cut, too?

Mr. REDMOND. Yes.

Mr. SILES. Senator?

Senator HEINZ. Yes, Mr. Siles.

Mr. SILES. A great deal of what Dr. LaFleur and Mr. Redmond said touches on my situation. And yet, if I may comment in response to the question that you just asked——

Senator HEINZ. Yes.

Mr. SILES. Part of the decision is made before the person gets to the care in the hospital. The person decides not to go.

Senator HEINZ. Oh, yes. That is what Dr. LaFleur was testifying to.

Mr. SILES. Exactly. I would say, in my own case, something like one out of ten times that somebody I think needs some sort of care in our family do we actually do it.

Senator HEINZ. Yes. That is a well-taken point. It shouldn't be.

Mr. REDMOND. Postponing of care only results in more expensive care having to be delivered later on.

Senator HEINZ. Now let me ask you a different kind of question. I am trying to get at the shortcomings in our existing system with a little bit more of a microscope. Let us assume that everybody that came to your hospitals did in fact have health insurance, what I will call "typical health insurance." Would there still be uncompensated care under the average type of health insurance policy existing today?

Mr. REDMOND. Well, what we have seen over the past several years, as the focus has been on cost-containment, has been to shift some of the cost to the individual, through larger copayments and deductibles. That leaves the health care provider having to collect that amount.

Senator HEINZ. And to what extent is that a problem?

Mr. REDMOND. It is a problem particularly from a lot of low-income individuals. It also requires extensive credit and collection activities on the part of the hospital, because you can't take the baby back, or you can't take back the care that you have already given. I mean, it is not like selling TV sets. And it has clearly increased the amount of so-called bad debt among hospitals as insurance policies provide less and less first-dollar coverage.

Senator HEINZ. How much of that trend in reduced first-dollar coverage, in your judgment, and this clearly has to be a subjective judgment, is reducing the cost of health care to the employer, and how much of it is, shall we say, genuinely necessary to reduce overutilization?

Mr. REDMOND. That is a tough question. I mean, certainly the theory has been to shift some of the first-dollar coverage off to the individual as an attempt to try to instill some sort of cost-consciousness on the part of patients so that they don't overutilize health care services. And there have been numerous studies that have shown that. That has not generally been the case, though, with low-income people, who will tend to defer that coverage, but simply because they can't pay the $2 copayment for prescription drugs or the $5 copayment to see the family physician, or the $250 copayment to be admitted to a hospital for an elective procedure.

Senator HEINZ. One last question: You mentioned that in Pittsburgh there is a higher rate of uncompensated care than in other areas.

Mr. REDMOND. Higher rates for uninsurance.

Senator HEINZ. For uninsurance, which I assume is because of the relatively higher unemployment rate in Western Pennsylvania.

Mr. REDMOND. Yes, and the shift in the economy.

What we have seen in Pennsylvania, as we move more into a service economy, is that there is less likelihood that the person is going to have health insurance coverage and certainly less of an opportunity perhaps for the dependent to have that coverage.

Senator HEINZ. Yes.

What I wanted to ask about is: Are there some types of hospitals that provide higher levels of charity care than others? And if so, what do they tend to be?

Mr. REDMOND. Well, what we have seen in Pennsylvania is interesting, and is a little bit different than the rest of the country, and that is that a fairly well-distributed amount of care is provided by hospitals. I think that is in large part due to the nonprofit status of hospitals in Pennsylvania. We largely have a nonprofit hospital system, particularly in the Pittsburgh area, where the care is fairly well distributed among the hospitals.

But those institutions that primarily serve the children and maternity cases in the Pittsburgh area, the Children's of Pittsburgh, McGee-Women's Hospital, and high-volume trauma hospitals like Allegheny General, Presbyterian-University Hospital, and Mercy Hospital would have high volumes of uncompensated care.

Senator HEINZ. One other question, which is: There are other sources of revenue to hospitals besides income from insurance and fees from patients. What has happened to those revenues, such as public subsidies, charitable contributions, university support?

Mr. REDMOND. Well, generally those kinds of support have dried up. Now, a number of the hospitals in Pennsylvania that have been around for some time, and we have the oldest hospitals in the nation, have some good endowments that have helped to offset some of the cost of care. But that simply is not enough in order to deal with this problem.

Senator HEINZ. Dr. Wolferth, you indicated that the average trauma admission costs a hospital $13,000, and you gave a hypothetical example. But you are from Hahnemann University Hospital.

Dr. WOLFERTH. Yes, sir.

Senator HEINZ. Excuse me for not knowing this. I assume Hahnemann has a trauma facility.

Dr. WOLFERTH. Yes. We had the first Level One trauma center in Philadelphia.

Senator HEINZ. Do you get a lot of uncompensated care? And if so, how many cases a year?

Dr. WOLFERTH. The total admission rate to the trauma service at Hahnemann is approximately 1,400 patients per year.

Senator HEINZ. How many of those are basically indigent?

Dr. WOLFERTH. About 400.

Senator HEINZ. About 400. So the numbers that you gave of six and a half million is not far off from where you are now.

Dr. WOLFERTH. No, sir, it is not.

Senator HEINZ. It is costing you better than $5 million. How can you stay in business?

Dr. WOLFERTH. Overall, Hahnemann University Hospital last year provided over $6 million in uncompensated care.

Senator HEINZ. How can you maintain that care?

Dr. WOLFERTH. I don't think that we will be able to do that indefinitely. The commitment of institutions, particularly with respect to trauma care, is an acute problem around the United States, not just in Philadelphia or Pittsburgh.

Senator HEINZ. Suppose you went broke? Or suppose whoever is the angel who has the deep pockets said, "Sorry, that $6 million loss in this trauma care is too much. We don't want to have a second-rate trauma center. We don't want people dying on a stretcher because they are not getting adequate care or because we don't have properly trained people. We are just going to close that trauma center at Hahnemann." What would happen to the people who come to that trauma center, or who would otherwise have come to that trauma center?

Dr. WOLFERTH. I think a lot will depend on whether what I expect happens, that other hospitals will have precisely the same problem in our area, and we will see what is happening in Los Angeles and in Miami: People are dying.

Senator HEINZ. Who are these people that are dying?

Dr. WOLFERTH. It doesn't necessarily mean that it is the person that is uncompensated, because, as you said, when you have a trauma patient you usually don't have time for a wallet biopsy. You have time only to do those things that are truly lifesaving.

I appeared with Dr. Raymond Alexander, who is in Jacksonville, Florida, last week. Patients are being flown 200—300 miles out of Miami. No one knows whether they have insurance or not, because they simply aren't being taken care of.

Senator HEINZ. Who are these people? Are these gunshot victims? Are they from automobile accidents?

Dr. WOLFERTH. No, sir. These are people who do not necessarily sustain urban violence such as penetrating injuries. Approximately 30 percent of those will be that type. The rest will be people who have sustained major fractures from vehicular accidents, industrial accidents.

Senator HEINZ. So they might have been struck by a car?

Dr. WOLFERTH. More than likely. And half of those people that are involved in an automobile accident, as you well know, are involved with an alcohol problem.

Senator HEINZ. Yes.

Do the preponderance of people who come in with trauma injuries tend to be preponderantly from an uninsured population?

Dr. WOLFERTH. It varies around the country greatly. In Pennsylvania the percentage is about the average percentage that Mr. Redmond gave you. This is not true, however, throughout the United States. Many States do not have mandatory automobile insurance, and vehicular accidents account for 55 percent of all trauma that occurs in the United States.

For example, in California they have a problem that it isn't the person from the ghetto area who is shooting or stabbing, it is a person who might be involved in an automobile accident. So there is a different pattern throughout the United States.

Generally speaking, though, we find that approximately 30 percent of people who suffer major injury do not have adequate coverage.

Senator HEINZ. So it is a relatively higher percentage.

Dr. WOLFERTH. Yes, sir.

Senator HEINZ. There is some correlation between people being uninsured and being more likely to be involved with a trauma.

Dr. WOLFERTH. There definitely is a correlation.

Senator HEINZ. Yes.

One last question for Dr. LaFleur.

Dr. LaFleur, I understand that clinics such as yours depend on several sources of funding. Could you outline rather briefly, because we are going to be tight on time, where the money for your clinic comes from?

Dr. LAFLEUR. The major money for our corporation comes from the Federal Government in the form of grants. Other sources, like I said, are people that come to our office that are under an insured program or an HMO type program. Those are small amounts.

Senator HEINZ. How steady has the funding been in the last few years?

Dr. LAFLEUR. It has been decreasing, which has created more problems in the sense of staffing for the offices, which provide the primary type of health care.

Senator HEINZ. While the funding from the Federal Government has been decreasing, what has happened to your patient loads? Has it been increasing or decreasing?

Dr. LAFLEUR. The patient load I think has been increasing, at least from what I have seen in these few years.

Senator HEINZ. Is that because there are more people, or are people just getting sicker?

Dr. LAFLEUR. I think it is mainly because there are more people becoming disillusioned with the insurance type system and having more problems obtaining insurance.

Senator HEINZ. So, in a sense, you are picking up some of the people like Mrs. McNaney and Mr. Siles——

Dr. **LaFleur**. Absolutely.

Senator **Heinz** [continuing]. Who, if they are in your area, simply cannot afford the insurance and have to go to you.

Dr. **LaFleur**. Yes. We have a large number of patients who will drive literally 30 to 40 miles to come to the office.

Senator **Heinz**. Will you serve anyone?

Dr. **LaFleur**. We will serve anyone.

Senator **Heinz**. Anybody?

Dr. **LaFleur**. Yes.

Senator **Heinz**. So if I want to come up from Washington, DC, you will take care of me?

Dr. **LaFleur**. Absolutely. Yes.

Senator **Heinz**. Do you do a good job?

Dr. **LaFleur**. I think so.

Senator **Heinz**. All right. I am sure you do, but it must be tough.

You have all been extremely helpful in laying out various aspects of this troubling and extremely complex problem. I want to thank you for helping us define that problem and all of its various components. It is a bigger and more complex problem than even you have been able to cover today, but it is a very significant and helpful start. So I want to thank each and every one of you for your participation in our hearing, and I thank you for your testimony. I may end up sending a few interrogatories, questions, to some of the witnesses if I find that I haven't covered all of the ground I wanted to.

Thank you very much.

Let me say, by the way, while our next panel is coming forward, that I am deeply indebted to Wilkes College for the use of this facility. Dr. Briesetch was kind enough to bring me up here this morning and introduce me around. I should have thanked him and the college at the very outset for their hospitality and generosity, but I would not want the record to be closed or be incomplete without thanking him.

Could I ask our next panel, please, to come forward and take their seats?

Our witnesses that are coming forward are Ernest Sessa, the Executive Director of the Pennsylvania Health Care Cost Containment Council; Gilbert Tough of Blue Cross of Northeastern Pennsylvania here in Wilkes-Barre; and James Campolongo of the Pennsylvania Manufacturers Association; and Curt Hules of PENNPIC.

I would like to ask Gil Tough, who I know has an appointment, to be our leadoff witness, even though I think Mr. Sessa might have expected to have gone first. I hope you will permit us to reverse the order slightly.

Mr. **Sessa**. No problem.

Senator **Heinz**. So, Gil, please proceed. It is nice to see you again, and thank you for taking time out of your busy schedule. We want you paying those claims just as quickly as possible.

STATEMENT OF GILBERT TOUGH, BLUE CROSS OF NORTHEASTERN PENNSYLVANIA, WILKES-BARRE, PA

Mr. **Tough**. Good morning, Senator Heinz.

I am Gil Tough, president and CEO of Blue Cross of Northeastern Pennsylvania. My comments this morning are on behalf of the Commonwealth for Blue Cross plans. We appreciate the opportunity to testify before you on the issue of health care for the medically indigent.

Our basic mission as Blue Cross plans is to offer quality, affordable, and accessible health care to all the residents of the Commonwealth.

To carry out this mission, we offer open enrollment, we do not age rate, we do not underwrite coverage based on health or economic status, we insure everyone regardless of risk, we do not cancel coverage because of extensive use of benefits, and we community rate.

That philosophy and practice has been carried through with innovative programs implemented by us to help keep the percentage of medically indigent in Pennsylvania well below the national average.

Two of those innovative programs are our own Plan's program for the unemployed, and Blue Cross of Western Pennsylvania's "Caring Program for Children."

In general, we believe that there are currently existing a variety of alternatives for providing health care to the medically indigent.

We believe that the basic thrust of any effort should be in the context of what we call "marginal improvements in coverage." We believe this approach is the most realistic, the most practical, represents the least traumatic way of dealing with a complex health care system, and best allows for setting priorities. We also believe it will involve the lowest incremental cost.

Within the basic approach, here are some of the considerations we believe are important:

Refinements in the medical assistance program should continue. These should include:

The simplification of provider administrative responsibilities at the State level;

The development of an outreach program to help remove the perception that sometimes stigmatizes these programs as only for the poor. Those who are eligible should be encouraged to recognize that it is part of the social safety net, exactly as unemployment compensation is a part of the safety net;

Outpatient care must be further encouraged through an increase in the allowances for providers, and also through programs to encourage financially and otherwise primary physician management of a patient's health care. Pennsylvania's Blue Cross Plans rely on precertification, second surgical opinions, utilization review, and managed care to accomplish these goals. These approaches should, over time, prove to be cost effective enhancements to the program and are all steps to be taken.

While Blue Cross Plans are willing to consider additional programs that would assist those who are uninsured or underinsured, it must be recognized that any new subsidized programs we may undertake must draw their subsidy dollars from the same pool that our current subsidized programs rely on.

Statewide, we insure nearly 7 million people, of whom almost 375,000 are nongroup hospitalization subscribers under 65. Last year we subsidized coverage for our nongroup hospitalization and major medical subscribers by over $79.3 million, contributed $49.9 million to assist hospitals in providing charity care, and also subsidized Medicare supplement subscribers. These moneys ultimately come from our employer customers. We cannot increase the subsidy levels without jeopardizing our competitive position.

Nevertheless, we believe there are opportunities to use the private sector, for instance, subsidizing persons currently ineligible for medical assistance so that they could choose either to buy into medical assistance or to buy into available private insurance programs. We particularly believe in the desirability of preserving some element of consumer choice for all segments of the population.

At the same time, it will be important in developing any program to distinguish clearly between those persons who cannot obtain a health care program and those who have chosen not to obtain such a program. For example, it appears that there are approximately one million persons in Pennsylvania estimated to be uninsured. But of those, approximately 200,000 have incomes in excess of $22,400, or 200 percent of the Federal poverty level. These persons may have the resources to protect themselves but have not done so. It seems to us, therefore, that the dimensions of the problem are really best measured by the people who not only lack insurance but also lack the resources to purchase it.

Finally, we note that the preliminary work of Levin & Associates in studying the indigent care issue in Pennsylvania has essentially indicated that the biggest problems of access to health care are in the primary care area.

Moreover, not only is inpatient care available, but there seems to be no current crisis in the funding of inpatient care.

These observations confirm what our own analyses have suggested over the past several years.

It is important to recognize that, fortunately for the Commonwealth, most Pennsylvania hospitals are nonprofit hospitals with a tradition of serving the entire community and, we believe, an obligation to continue to do so.

We recognize the difficult choices many hospitals face today, in a time when competition in various forms has become far more important in the health care industry. But ultimately it is equally important to recognize that hospitals exist not merely to survive the competitive struggle but also to serve. We hope the continuing fulfillment of that obligation will be one of the key elements in any solution to the problems of the medically indigent.

We believe any program designed to address the indigent care issue must be done in a building-block fashion because of the complexity of the issue.

And because of the mission and the activities of the Pennsylvania Blue Cross plans, our continued competitive viability must be ensured.

We appreciate your time, Senator, and the opportunity to testify for the record on this complex issue. Thank you very much.

Senator Heinz. Mr. Tough, thank you very much.

[Mr. Tough's prepared statement appears in the appendix.]

Senator HEINZ. You indicated that you are able to have open enrollment, you don't age rate, you community rate, you insure everyone regardless of risk, you don't cancel coverage because of extensive use of benefits. That makes Blue Cross in our Commonwealth relatively unique. My understanding is that that is not the case with the Blues in most other States. Why are you able to do this?

Mr. TOUGH. Well, there are two factors. No. 1, I think the Pennsylvania Insurance Department over the years has adjudicated that provision that we provide open enrollments, and that the community-rating aspect really does not include any age rating. You know, I have been with Blue Cross for 30 years, and at no point in that 30-year period have we age rated.

In the other, that we do not underwrite coverage based on health or economic status, it is really why we are nonprofit in that category.

Senator HEINZ. Mr. Siles, when he was looking for insurance, found that he and his wife were excluded for two different conditions. Now, does Blue Cross do that, too?

Mr. TOUGH. Well, I must clarify one point: We do have pre-existing exclusion for a specific pre-existing condition. An example might be diabetes. If they declare that on their application when they enroll, even on a nongroup basis, there is a 12-month waiting period. However, they can be treated for any other illness that occurs other than diabetes; it can be a heart attack or any kind of illness, and we will supply hospitalization, or Blue Shield will supply coverage other than a related diabetic condition.

Senator HEINZ. Well, obviously we have got a situation, as described quite specifically by Mr. Siles today, where he can't afford both to pay for his treatment and pay for insurance; it is a catch-22 situation.

Is there anything we could do? Could we set up some kind of reinsurance mechanism, something to encourage insurers such as the Blues or the private insurance industry to cover people during or without these waiting periods?

Mr. TOUGH. It is possible, an innovative approach to a pool. Several times in Washington I suggested some type of pooling on that aspect for even malpractice insurance, you know, for hospitals; although, the Pennsylvania hospitals took care of their own.

I think it is a matter of spreading the risk, and that it has some interesting aspects in it.

Senator HEINZ. Well, Gil, I know you've got to go. Thank you very much for being with us. I appreciate your assistance.

Mr. TOUGH. It is a pleasure to see you in Wilkes-Barre.

Senator HEINZ. Thank you. It is nice to be back.

Mr. Sessa, please proceed. I am sorry to have interrupted you.

Mr. SESSA. That is quite all right, Senator.

STATEMENT OF ERNEST SESSA, EXECUTIVE DIRECTOR, PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL, HARRISBURG, PA

Mr. SESSA. Thank you very much, Senator.

My remarks today have to do with something that happened back in July of 1986 in the General Assembly of the State of Pennsylvania. They passed a piece of legislation unanimously which created a Pennsylvania Health Care Cost Containment Council, which is something that I think is unique in the country. It is made up of a 21-member council, and it is an independent State agency.

I appreciate the opportunity to share with you today some of the remarkable accomplishments that have happened in the past 17 months relative to the actions of this council. There are 21 citizens of the State of Pennsylvania who are unpaid volunteers appointed by the two Houses of the General Assembly and also the Governor, who have worked diligently to get into the problems of health care delivery in our State, and they are mostly representing decision-makers in the health care field, including all aspects of it.

The main purpose of this council is data collection to provide information on cost and quality of inpatient hospital services in our State. We also are to review mandated legislation involving insurance products that would come from the legislature, that would mandate that every insurance company doing health care business in the State of Pennsylvania would have to provide certain coverage that was legislated.

The last thing we are doing is looking at the medically indigent problem. The legislation mandates that we study the problem and come up with a plan to go to the General Assembly and to the Governor, and we have done that. As a matter of fact, we passed that plan yesterday, and it will go to the Governor and the General Assembly tomorrow, based on the mandates of the legislation.

I would like to summarize what this plan will do. I had planned on going into a lot of the study results. I will just briefly go over this.

I think you have heard a lot of those today from Jim Redmond and other people who have testified. The Hospital Association serves on the Council as well as the Pennsylvania Medical Society.

Senator **Heinz**. Without objection I am going to put your entire testimony into the record, so we will have all the specific findings in the record. Go ahead and summarize the actual plan itself.

Mr. **Sessa**. OK.

The plan itself, based on the studies, really came up with the overall view that there were a million uninsured individuals in the State of Pennsylvania, and of a lot of those uninsureds, two-thirds were employed. The medical expansion, the Medical Assistance Program in the State of Pennsylvania also had problems, and there are also 700,000 to 800,000 uninsured people, and I think 1 or 2 people today expressed that situation as to what happens to a person who is underinsured as well as uninsured.

So, we knew what our problem was. Now we have to set out with a direct approach on how to solve this problem.

This was done through a study from Lewin Associates from Washington, DC. It came up with a draft plan for the Council to be guided from, and we went out in the State of Pennsylvania and held hearings. We had three hearings early in the year and then eight more hearings in the latter part of the year, in which we went out and asked the individuals who were impacted by problems with the delivery of health care, with access to health care, their input—what they perceived as the problem and what could be done about it.

After doing all that, we came up with the situation that we have some various approaches in trying to solve this problem.

One approach is to expand insurance, to expand insurance not only in the medical assistance area by making more people eligible for medical assistance by raising the threshold of the income level but also by expanding it into the area where people were employed but had no insurance, and there are approximately several hundred thousand people in that category, 400,000 to 500,000 people. The problem was, how do you come up with a mechanism to do that?

Our thrust was to encourage employers to provide insurance, similar to what has happened in Massachusetts and similar to what Senator Kennedy is proposing in Washington.

However, that is not as easy as it appears to be. There are problems with that. But the thrust of trying to get small employers, who are predominately the ones who do not provide insurance, to provide this insurance, we had to come up with a mechanism, and we had to come up with a draft plan that would include all of the things that really should be in a good product that will contain costs as well as make access available to individuals, and those plans are described in my comments.

In addition to providing that kind of insurance, we also know that there will be some employers who will not provide insurance.

So, in order to provide a mechanism to get to those people who are not in the insurance program, we came up with a concept of a trust fund that would get contributions from the various components of the health care delivery system, including the State government, including employers, including hospitals, physicians, insurance companies.

This money would go into a trust, and then the trust would be used to subsidize those people who couldn't afford insurance, those people who are 150 percent below the poverty level, those people who were unemployed and had no resources, and those people who were uninsured or temporarily unemployed.

That trust fund would dispense money into those areas, including service initiatives in the various regions of the State where unemployment is high and physicians and hospitals and primary care centers are attempting to provide that care, however they find themselves in some financial difficulties because of the various reasons explained to you today, with shortfalls in the MA payments and shortfalls in Medicare, and all these areas. We want to bolster that up, also.

Senator HEINZ. Mr. Sessa, are you almost through? We have got two more witnesses, and I am going to run out of time very soon here.

Mr. SESSA. OK.

In order to summarize what we are trying to do, it is a multifaceted plan that is now in the hands of the legislature and the Governor. This plan brings with it a price tag.

Senator HEINZ. What is the cost?

Mr. SESSA. Collectively, it could be as much as $700 million.

Senator HEINZ. And how is that split between employers and public sources?

Mr. SESSA. The employers are responsible for approximately, I would say, $200 million, and the Federal Government and State Government another $500 million.

Senator HEINZ. I wish I had time to go into that. Obviously it is going to take the legislature a long time to get into all of that.

Mr. SESSA. They have 120 days to look at our plan or come up with another plan, or come up with some kinds of alternatives to do that.

Senator HEINZ. Very well.

I am going to have to ask you to withhold further testimony at this point so I can get to hear from Mr. Campolongo and our other witness.

Mr. SESSA. I understand.

[Mr. Sessa's prepared statement appears in the appendix.]

Senator HEINZ. Mr. Campolongo—Jim?

Mr. Campolongo needs to be identified, also, in all candor, as a former staff member of mine; but the view that he is about to espouse may or may not represent my views.

So, Jimmy, please proceed.

Mr. CAMPOLONGO. As a former staff member, I will try to be quick with this, as I know you are under time constraints.

STATEMENT OF JAMES CAMPOLONGO, PENNSYLVANIA MANUFACTURERS ASSOCIATION, PHILADELPHIA, PA

Mr. CAMPOLONGO. My name is James Campolongo, and I am with the Pennsylvania Manufacturers Association. I am speaking today on behalf of the National Small Business United, an organization of 50,000 small business owners throughout the United States, and I am also here representing the Smaller Manufacturers Council, a regional group from the Tri-State area of western Pennsylvania, eastern Ohio, and northern West Virginia.

SMC has 2,800 member companies, which include service, professional, retail, and wholesale as well as manufacturing businesses. Approximately 71 percent of these companies participate in SMC's association-sponsored Small Group Insurance Plans.

Proposals to mandate employer-provided health care coverage are a major concern to small business owners. In fact, opposition to mandated health care was voted as the number one priority on the small business agenda by the more than 150 small business leaders throughout the country who participated in NSBU's annual leadership conference last winter.

NSBU and SMC's objections to mandating health coverage are not based on any philosophical objection to the ideas stated objective of increasing access to and controlling the cost of health care coverage. Our objections are based on a sincere belief, based on our experience as an advocate for small business, that there are better ways to achieve this task.

NSBU and SMC take issue with the contention of those who support legislation to mandate health coverage that the only way to increase the incidence of health care among small companies is to make employers buy it. There is a real problem with the assumption that millions of small employers have consciously decided not to provide coverage to their workers because it will save them money.

We believe that everybody wants group health insurance at affordable prices, and we know that, since the insurance industry does not provide group coverage to partial groups, small employers cannot legally deny their employees coverage without foregoing coverage for themselves.

NSBU and SMC support constructive solutions to the nation's health care problems by taking steps to improve the voluntary market-driven system of employee benefits.

We believe there are many reasons why health care coverage isn't available to small companies:

One of them is medical underwriting, through which insurance carriers may reject whole groups for coverage if only one member of a small company's workforce has an illness. Another is the Federal Tax Code's discrimination against unincorporated companies' investment in group health coverage. Sole proprietors must use after-tax dollars to buy their coverage, which is one reason that approximately 2 million of the Nation's uninsured are self-employed people.

Other reasons have to do with the cyclical nature of carriers' participation in the small group market, and the reluctance of carriers to write corporate group coverage down to one life.

The industry practice of treating the small group market as a retail market serves as a disincentive for carriers to make coverage available on a wholesale basis through associations like SMC and NSBU.

We fear that the mandated-benefit approach will lead to even less competition in the marketplace for smaller employers' health care dollars. We are confident that mandating health coverage will lead to dramatically higher costs for small employers. We are further concerned that the idea, together with other such proposals before the Congress, will have a negative impact on the ability of small businesses to create jobs in the economy.

Before we consider the enactment of mandates, NSBU and SMC believe that we must first take whatever steps are necessary to assure that the voluntary marketplace is working as well as it can, and that everyone who wants coverage can obtain it at a reasonable cost.

Congress could be very helpful in reducing the current regulatory obstacles that limit the availability of health coverage to the small employers.

To begin, you can extend to unincorporated businesses the same tax treatment afforded to corporations for their investments in group health care.

You might also consider legislation similar to the Risk Retention Act, which would make it easier for small companies to combine their buying power to purchase more affordable coverage through associations.

You might take steps to more vigorously enforce regulations designed to assure that employers' health plans are operated fairly and in a nondiscriminatory fashion.

These steps would lay the foundation for at least a partial solution to the problem of the working uninsured. The cost of taking these steps would be minimal, especially in comparison to the costs of mandating health care benefits.

We should take steps to make our remarkable voluntary system work better, rather than institute government mandates that are costly, inflexible, unworkable, and unenforceable.

Thank you, Senator, for the opportunity to be here today.

Senator HEINZ. Mr. Campolongo, thank you very much.

[Mr. Campolongo's prepared statement appears in the appendix.]

Senator HEINZ. Mr. Hules?

STATEMENT OF CURT HULES, PENNSYLVANIA PUBLIC INTEREST COALITION, WILKES-BARRE, PA

Mr. HULES. Good morning, Senator.

You already have my testimony, so I am not going to read it all to you.

Senator HEINZ. Without objection, all of it will be placed in the record.

Mr. HULES. OK.

I am Curt Hules. I am the northeast regional director of the Pennsylvania Public Interest Coalition, PennPIC. On behalf of our members here in northeastern Pennsylvania, I would like to welcome you to Wilkes-Barre. I just have a couple of things to say.

I just want to reiterate what I am sure you have already heard from a lot of businesses, labor organizations, health care providers, many employers, and that is that we have to do something about these uninsured.

You have heard different figures here today. You have heard that at least one-half of the uninsured people in Pennsylvania are working, productive citizens. They aren't freeloaders, Senator, and it is critical from an economic standpoint that our health care system be adjusted to protect these workers.

Senator, you know you will be considered an important swing vote when the Senate votes on Senate bill 1265, the Minimum Health Care Benefits Act for All Workers, when it comes to the floor. We are urging your support for that.

And to follow up on what the gentleman next to me said, his concerns are valid; there has to be a way to make health insurance affordable for smaller employers as well.

Senator HEINZ. OK, good.

Mr. HULES. That is about all I have to tell you.

Senator HEINZ. Good.

[Mr. Hules' prepared statement appears in the appendix.]

Senator HEINZ. First let me start with Jimmy Campolongo.

If, somehow, we could wave a magic wand and make, for small employers, group health insurance available at the same price as large employers are able to either provide it or get it—and there is some information that suggests that small firms pay as much as 40 percent more per capita for coverage as large businesses—to what extent would small employers provide more employer coverage for health insurance?

Mr. CAMPOLONGO. Directly to small businesses, or through associations?

Senator HEINZ. Well, however you did it. There are roughly, say, 15 million people who work for businesses, most of whom—not all of whom, but most of whom—are relatively smaller businesses. Some of them are service businesses, some are large businesses like large chains operating service businesses.

But among the population of employees working for small businesses which do not now cover their employees with any health insurance whatsoever, what would happen in the way of those employers taking up the challenge of additional coverage for their employees if the cost was affordable as I have defined it, that is to say it costs no more than it would cost anybody else?

Mr. CAMPOLONGO. Well, that certainly is the magic-wand solution.

Senator HEINZ. That is.

Mr. CAMPOLONGO. Because cost, affordability and availability of insurance——

Senator HEINZ. Now, affordability is not what he wants to pay; affordability is getting it at a cost comparable to some of the relatively large employers.

Mr. CAMPOLONGO. Exactly, and not according to the Cleveland Study, 40 percent higher to what larger businesses are paying.

Senator HEINZ. Yes.

Mr. CAMPOLONGO. I would think we would solve all of the problems of the smaller employees if we were able to offer them insurance at what the larger companies are trying to do.

Senator HEINZ. So you think the uptake would be virtually 100 percent?

Mr. CAMPOLONGO. If the magic-wand theory holds, you would hope so.

Senator HEINZ. If that were true, if we could get you health insurance at that kind of price, and I don't know if we can, would you object to the kind of mandate that is in S. 1265. which says you have got to operate as such?

Mr. CAMPOLONGO. Exactly. The objections to S. 1265 are primarily——

Senator HEINZ. Remember, my question is a two-part thing . Somehow we provide this coverage at this lower rate, say it is 40 percent lower than the average PMA member now who gets quoted to them; and, secondly, you say, "But when that is available you have got to cover the people in your firm with that." Now, what kind of a problem would that be, if any?

Mr. CAMPOLONGO. There would be a problem. If it were affordable and the employer can provide it to the employee without the Government coming into his shop and telling him to do it, I think he would rather have that situation than having it available and you and your colleagues in Washington telling him——

Senator HEINZ. Wouldn't we all? [Laughter.]

Mr. CAMPOLONGO. Exactly.

Senator HEINZ. But that is not the question. The question is, what kind of problems would that create other than hard feelings?

Mr. CAMPOLONGO. I can't answer that. I don't know.

Senator HEINZ. One of our witnesses, Mrs. McNaney, testified that their small family farm couldn't get HMO coverage, for example. Is that a problem for many small firms?

Mr. CAMPOLONGO. They can't get HMO coverage, and they can't get coverage from companies like Blue Cross and Blue Shield. One of the reasons for that is because it costs more to insure a smaller company or a smaller farm. There is evidence to support that to insure two business entities that employ five people is double what it would cost to insure one business entity that employs 10 people.

Senator HEINZ. Let me ask Mr. Hules.

Mr. Hules, you are basically advocating the Kennedy bill, mandating that everybody be provided a health insurance employer-paid, a particular benefit package, Federal minimum standards for those benefits.

In the current environment in which the small employer, as you have just heard today, is paying perhaps 40 percent more per employee, why isn't the small employer just going to go out of business? Why isn't the Kennedy bill going to put them at a terrible disadvantage?

Because we have had the insurers saying, "We charge the little guys more," we have the employers saying, "We are being charged more." We have studies that say, "They are being charged more." Why doesn't that either drive small businesses out of business or put them at a competitive disadvantage that is backbreaking? How do you deal with that?

Mr. HULES. All right, I will try to answer that, Senator.

First of all, I think you have to reshape the question in a form that is factual, first of all.

Senator HEINZ. Well, I think what I said is factual.

Mr. HULES. The provisions that are in the Kennedy bill, when you boil it down to how it affects Pennsylvania, we are talking about in terms of what the employer will——

Senator HEINZ. Forget Pennsylvania; just small employers.

Mr. HULES. It is an hourly wage increase for about 40 cents per hour.

Senator HEINZ. Well, that is not the issue. It is not a question of is it 40 cents or $1.40; the question is: If it is 40 percent more for small employers and 40 percent less for big employers, if you will, doesn't that put the small employer at a competitive disadvantage?

Mr. HULES. Oh, nobody is disagreeing with that.

Senator HEINZ. Because, whether we like it or not, the reality out there in the marketplace is for the individual person, for the self-employed person, for the small business people, health insurance costs more. OK? You have got to be a member of a large group to be able to get, as an employer or an individual person, affordable health insurance. That is a reality.

Now, how do we deal with that reality?

Mr. HULES. Well, I think the Kennedy bill addresses that.

Senator HEINZ. How?

Mr. HULES. It sets up in companion legislation a system where the smaller businesses will have the same tax breaks as the larger businesses.

Senator HEINZ. But if they have got higher costs, how does the tax break help them?

Mr. Hules. Well, whether they have higher costs, you are not going to be able to prove that or disprove that right here at this hearing. I believe the Kennedy bill also offers them——

Senator Heinz. I am not trying to get you to say that there aren't, but let us assume—assume—that the preponderance of testimony here today is accurate, OK? Just assume it, without saying that it is. Assume it. Isn't that a potential problem?

Mr. Hules. Well, I have been saying that it is important that small businesses be able to get the same insurance that the larger corporations are getting, for the same costs.

Senator Heinz. Let me ask Mr. Sessa.

Mr. Sessa, this obviously has to have been a problem that you ran into absolutely head on.

Mr. Sessa. Right.

Senator Heinz. What do you do about it?

Mr. Sessa. One thing we are trying to do, Senator, is establish a multiple employer trust for small businesses, where they can buy as a large group, with volume, and with those numbers hopefully they will be able to equalize that 40 percent differentiation there so that they can buy insurance as cheap as anyone else.

And also to look at the small firms who would have problems getting insurance, to try to subsidize them through the trust in some manner to be able to provide, with everybody contributing for that.

Senator Heinz. Mr. Campolongo, have you had a chance to look at this proposal yet?

Mr. Campolongo. No, I have not.

Senator Heinz. As it has been described to you—and admittedly it is literally "hot off the press," and I hope Mr. Sessa has had a chance to proofread it; I don't know.

Mr. Sessa. Well, yes, we did proofread it, Senator.

Senator Heinz. To what extent, as you understand what he said, would that be of major benefit to small employers?

Mr. Campolongo. I am going to have to read it, Senator. He went into certain points, and I can't comment on something that just got off the press.

Senator Heinz. That is fair enough. I wouldn't criticize anybody for being unwilling to vote on a bill that he hadn't read. [Laughter.]

Mr. Sessa. Yes, that is dangerous.

Senator Heinz. The only problem is that we get some bills down in Washington, DC, that people don't read, and we vote on them anyway.

It would be very useful if you, Mr. Sessa, could provide a copy of your new report for the record.

Mr. Sessa. I intend to do that Senator. Yes.

Senator Heinz. You know, I may have some additional questions for all of you. I want to thank you for having really made a major contribution to our hearing today.

What I think we have learned is that people are uninsured for a very wide variety of reasons. Some of them are too poor to buy any kind of insurance, but they are too well off to qualify for Medicaid. Some are employed, but the employer doesn't provide. Some are young, by the way, and don't think they need any help. Often young people think they are going to live forever. I used to be young once, myself. Some, as we heard from our first witness or two are uninsurable risks. One-third are children.

What we have learned that even if every employer provided insurance to employees, not all uncompensated care would be paid for because of the deductibles and co-pays, and many part-time marginal workers would not be covered. Many people would need financial help to pay their premiums, and many people would still be too sick to find insurance.

I don't think we should take those problems as any kind of insurmountable hurdle to be overcome; but it does suggest that any solution is going to have to respond to the complexity of that problem, as I have outlined it, and we will have to use a variety of approaches including additional Federal spending for Medicaid, if we are to have any kind of a level playing field for the people that need it.

Undoubtedly employers are going to have to play a part. And then we are going to seek, Mr. Sessa, a variety of very creative solutions, and I look forward to reading your report, because we are in need of them.

Mr. SESSA. Well, they were slaved over and worked over, and hopefully they will be constructive.

Senator HEINZ. I thank you all for being here.

The hearing is adjourned.

[Whereupon, at 10:45 a.m., the hearing was concluded.]

APPENDIX

ALPHABETICAL LIST AND MATERIAL SUBMITTED

TESTIMONY

by JAMES CAMPOLONGO

on behalf of
NATIONAL SMALL BUSINESS UNITED
and
SMALLER MANUFACTURERS COUNCIL

June 30, 1988

Senator Heinz, members of the Senate Finance Committee, I appreciate this opportunity to comment on a very important piece of legislation. My name is James Campolongo and I am with the Pennsylvania Manufacturers Association. I am speaking today on behalf of National Small Business United, which has a membership of 50,000 small businesses around the country.

I am also here representing the Smaller Manufacturers' Council, a regional organization with more than 2,800 member companies which employ approximately 60,000 people in the tri-state area of Western Pennsylvania, eastern Ohio and northern West Virginia. The members of SMC include service, professional, wholesale and retail as well as manufacturing businesses. Nearly 71 percent of these companies are enrolled in association-sponsored small group health insurance plans.

NSBU and SMC agree that our nation must take decisive action to address the health care needs of America's uninsured. We recognize that census data indicates that a large percentage of the uninsured are in some way connected to the workplace and understand that the efforts of the business community must be engaged in order to assure the greatest possible access to health care coverage for as many Americans as possible. It is apparent that the problem of the working insured is especially acute in the small business community and that steps must be taken to increase the incidence of health care coverage offered by small employers.

Our objections to S. 1265 are not based on philosophical differences with the bill's stated objective of increasing access to and controlling the cost of coverage. We believe there are better ways to achieve this task and we support constructive steps to improve the nation's voluntary, market-driven system of employee benefits.

NSBU and SMC have several objections to S. 1265. Specifically:

1. S. 1265 will be enormously costly.

The Congressional Budget Office has estimated that the first-year cost to business will be approximately $27 billion if S. 1265 is enacted. While that number is staggering, there is evidence to suggest it is considerably understated. This estimate may be reflective of the cost to business of providing coverage to currently uninsured full-time workers, but it ignores related factors. For example, a recent survey of corporate benefit plans, conducted by Towers, Perrin, Forster and Crosby, concluded that nearly 65 percent of corporate plans currently in place would not be in compliance with the levels of coverage mandated by S. 1265 if it were enacted today.

The cost of bringing those plans "up to code" (i.e. increasing benefit levels, providing mandatory duplication of coverage required by the legislation, extending benefits to part-time workers, etc.) could easily exceed an additional $50 billion. Under the existing requirements of S. 1265, 80 percent of this total $77 billion (or $61.6 billion) would be borne by employers; most of the remaining $16 billion would come from employees' after-tax income.

The CBO estimate was also curiously reticent regarding the impact of S. 1265 on federal revenues. An independent study, conducted by Robert R. Nathan Associates, Inc., estimates a loss to the Treasury of at least $35 billion, largely through the loss of tax revenues that will result from a reduction in employment. Even if this case is overestimated by 50 percent, it still indicates that S. 1265 would cause a federal revenue loss of billions of dollars. That estimate does not include the cost of revenues lost through increased deductions taken by corporations required to pay higher premiums, or the potentially enormous cost to the Federal government of administering and enforcing the new law.

2. S. 1265 contains no provisions to control health care costs.

While the first year cost estimates attached to S. 1265 are enormous, the plan designs specified by this legislation and the lack of underwriting controls mandated by the bill will further increase the cost of coverage. Business has ample reason to fear that additional levels of coverage and reimbursement for new covered benefits will ultimately follow the originally mandated level of benefits.

Industry insurance experts will attest to the need to maintain underwriting controls in the small group market. It is true that when you impose standards to keep costs under control, some individual will be denied coverage. But when you remove underwriting standards to include these individuals, costs will skyrocket.

The experience of regional small business organizations that belong to NSBU leads us to the conclusion that a significant number of the working uninsured are in groups which have been denied coverage for medical reasons. If that is true, forcing them into a program by revoking medical underwriting and other cost containment features is a prescription for disaster for employers who will be mandated to pick up the tab.

3. S. 1265 will not solve the problem.

The enormous costs attached to this bill might be justified if S. 1265 provided a decisive means for solving the problems of the nation's uninsured. But even assuming this legislation could be properly implemented and enforced, it would solve only two-thirds of the problem, at best. There would still be some 12 million unemployed, indigent, uninsurable Americans in need of care. This number could easily increase if employers respond to the legislation by reducing their workforces. The first to suffer from such retrenchment would be low-skilled, low-income workers who are employed part-time in lower-paying jobs.

4. Finally, there are workable alternatives that S. 1265 ignores.

Congress is understandably frustrated at its inability to deal with the problem of the uninsured in a comprehensive way. But the broad-brush approach embodied in S. 1265 is insensitive to the kinds of individuals who are loosely labelled "uninsured" and to the many regional, industrial, economic and even personal and political reasons why they are not insured. It is by no means a foregone conclusion that mandating employer-provided health care coverage will successfully address the many needs of the uninsured.

S. 1265 also ignores the possible cost-efficiencies which can be achieved by providing health care services through managed care arrangements, particularly HMO's, in favor of much more open -- and expensive -- coverage arrangement.

NSBU and SMC suggest that, rather than mandate coverage first and deal with the complications later, Congress should take steps to make certain that the voluntary market-driven sector is operating efficiently. Once the marketplace has enabled all those who can provide coverage to obtain it, the Federal government might them consider steps to make coverage available to those who cannot or will not provide coverage.

We believe that no single strategy will solve the nation's health care dilemma. What is required is a series of initiatives, which respond sensibly and creatively to the many problems which comprise the nation's health care crisis. NSBU and SMC, together with many other business groups, support the following initiatives, and we urge you to consider them.

1.) Provide full deductibility of health insurance premiums for proprietorships, partnerships and self-employed individuals.
It is universally agreed that the tax code discriminates unfairly against unincorporated companies in this area. Full deductibility would have a negative impact on revenues, but the impact would be small compared to the impact of S. 1265.

2.) Increase enforcement of existing regulations aimed at ensuring the fairness and non-discrimination of existing plans.
Surveys indicate that there is a chronic problem of underenrollment in many small companies' plans. Some of this is inadvertent, but a great deal of this underenrollment is due either to conscious discrimination on the part of the employers or to company policies which have the effect of denying coverage to employees who deserve it. Both

ERISA and IRS regulations contain provisions for civil and other penalties for such discriminatory practices. More aggressive use of these standards, particularly the new IRS non-discrimination rules which were incorporated into the 1986 tax act, would discourage such discrimination.

3.) Take steps to encourage the creation of multiple-employer insurance plans.
The use of associations, which combine the purchasing power of employers to produce better coverage at lower costs, is a concept given some consideration even in S. 1265 by the "regional insurer" concept. It is logical that such a pooling arrangement -- properly administered -- should both increase availability and reduce costs. Unfortunately, a variety of state and federal regulations, including outright prohibitions against the formation of METS (Multiple Employer Trusts) in some states and strict regulations on the design of METS by the federal government, have impeded the creation of more and better association plans. Such problems are compounded by a reluctance on the part of many insurers to underwrite such plans. Some of that reluctance is based on real problems related to adverse selection, medical underwriting and administration; however, some reluctance is also due to carriers' unwillingness to "wholesale" coverage through associations which can be sold "retail " to individual employers.

This type of initiative provides a real opportunity for political leaders, the insurance industry and small business groups to achieve a real consensus on a creative and co-effective means to expand the availability, and control the cost of, health care coverage in the small business community.

4.) Encourage innovation.
The health care needs of people living in communities around the United States vary widely, based on the parts of the country in which they live, where they work and the population density of their home communities. In addition to considering sweeping reform and its attendant costs and innate inefficiencies, government and business leaders need to pay attention to creative efforts to address these needs at the community level. A much publicized series of demonstration projects, underwritten by the Robert Woods Johnson Foundation, are only now entering the implementation phases; the success of these efforts is yet unknown. Government, providers, insurers and employers need to encourage these kinds of local, market-oriented activities of groups working cooperatively to ensure access -- at the community level -- to affordable health care.

S. 1265 has already served a high political purpose. It has focused the attention of both Congress and the business community on the growing dimensions of the problem of America's uninsured. It has pointed up the need to find ways to make group health care coverage more prevalent in the small group market. It has also demonstrated, with great clarity, that facing up to those issues will be expensive for both business and government. The price of solving the problem of the working uninsured will be a good investment if it's managed well.

It is our belief that other, more cost-effective means can be employed to achieve this policy objective. We will support vigorously any attempt to define and implement a co-operative agenda whose purpose is to increase the availability and affordability of health care coverage to small employers.

Given prompt enactment of the alternatives outlined above, the number of working uninsured Americans would be significantly reduced within three years. This is approximately the amount of time required to implement S. 1265 with any degree of effectiveness. The small business marketplace is large, diverse and complex. It is NSBU's belief that health care problems can be best addressed by private efforts at the local level, supported by well-defined Federal incentives and encouragement, rather than a massive federal program.

It is for all these reasons, despite our concern for the many issues which the bill attempts to address, that we must oppose S. 1265 visibly and vocally. It will cost billions of dollars, it cannot work and it will not solve the essential policy problem.

OPENING STATEMENT OF SENATOR JOHN HEINZ (R-PA)
SENATE FINANCE COMMITTEE HEARING
"EXPANDING HEALTH INSURANCE COVERAGE"
JUNE 30, 1988

GOOD MORNING: TODAY, SOME 202 MILLION AMERICANS HAVE HEALTH INSURANCE THROUGHOUT THE YEAR TO PROTECT THEM AGAINST THE UNANTICIPATED COSTS OF AN ILLNESS OR INJURY -- 37 MILLION AMERICANS DO NOT.

LIKE DAMACLES, AMERICAN FAMILIES WITHOUT HEALTH INSURANCE STAND UNDER A DANGLING SWORD OF FINANCIAL DISASTER. EVERY $60 FOR AN OFFICE VISIT OR $40 FOR A LAB TEST IS A DETERRENT TO CARE. ONE $54,000 BILL FOR A CAESAREAN SECTION DELIVERY AND NEO-NATAL CARE OF A PREMATURE BABY IS A FINANCIAL CATASTROPHE. AS MEDICAL CARE COSTS RISE AT DOUBLE THE RATE OF INFLATION, THE UNINSURED FIND THE COSTS OF COVERAGE INCREASINGLY PROHIBITIVE, AND THE RISKS OF EXPOSURE INCREASINGLY DISASTROUS.

WE HAVE BUILT WHAT IS OFTEN CALLED THE GREATEST HEALTH CARE SYSTEM IN THE WORLD, YET MILLIONS OF THE UNINSURED GET SUBSTANDARD CARE OR NO CARE AT ALL. TOO OFTEN THE FIRST PROCEDURE IN THE EMERGENCY ROOM IS THE "WALLET BIOPSY", WHICH CAN RESULT IN DELAYED OR EVEN DENIED NECESSARY SURGICAL CARE. THE LACK OF CARE IS A PARTICULAR THREAT FOR OUR CHILDREN. FOR THE 14 MILLION WHO DO NOT HAVE HEALTH INSURANCE, ROUTINE OFFICE VISITS, VACCINATIONS AND TREATMENTS FOR MINOR INJURIES BECOME A LUXURY THAT THEIR FAMILIES MUST STRUGGLE TO PROVIDE.

THE LACK OF HEALTH INSURANCE COVERAGE ALSO CREATES A GROWING FINANCIAL BURDEN FOR HOSPITALS AND OTHER HEALTH CARE PROVIDERS. EACH YEAR MORE THAN $7 BILLION IN HOSPITAL BILLS GO UNPAID. SOME HOSPITALS HAVE TO WRITE OFF AS MUCH AS $1 OUT OF EVERY $8 DOLLARS THEY NEED TO STAY IN BUSINESS. THESE GROWING LOSSES MAKE IT HARDER FOR WILLING HOSPITALS TO PROVIDE CARE TO THE UNCOVERED AND CAUSE others to turn the uninsured away or cut back on emergency room and other services.

This hearing marks the first time in the 100th Session of Congress that the Senate Finance Committee has looked into the problems associated with the lack of health insurance. I am pleased that the Committee has begun by coming to Pennsylvania -- this State has done more than most others to make health care available to its citizens. Pennsylvania's employers have traditionally provided comprehensive coverage for workers and their families. "Open enrollment" policies are available to individuals year 'round. And the Pennsylvania Medical Assistance program provides coverage to individuals with high medical costs under its "medically needy" standard, as well as more traditional Medicaid coverage to the poor.

Yet even with all of this, more than 1 million Pennsylvanians -- of them 345,000 children -- do not have protection against their health care costs. The State has set up the Health Care Cost Containment Council to develop proposals to expand health insurance to these people, and I am hopeful that the testimony they present today will give some guidance to the Senate as we struggle with these issues on a national level.

Today we will hear from families who have faced difficulty in getting care, providers, the insurance industry and the business community. Our first panel will discuss why, even though health insurance plans are available, 1.2 million Pennsylvanians are uninsured, what consequences this holds for their health and the financial burdens the cost of care place on hospitals. The second panel will discuss some of the options that are available for expanding coverage, and the political and economic difficulties inherent in some approaches.

I hope this hearing can help us in the Finance Committee develop the right mechanisms to enable everyone to get the medical services that they need, with reasonable payments to health care providers and equitable sharing of health care cost.

Today I am releasing a report that was prepared by the staffs of the Senate Special Committee on Aging and the House Education and Labor Committee which lays out the extent of the problem of the uninsured and the range of options available for expanding coverage. This information has been compiled as part of an on-going working group which I began over a year ago with members of the business community, labor unions, the insurance industry, and health policy experts. I am also pleased to be releasing today the first part of a study by the Congressional Research Service which provides background on the issues surrounding health insurance expansion. When complete, this study will examine the implications of various proposals to expand health insurance coverage.

I want to thank all of the witnesses who have agreed to be here today, and I look forward to hearing their testimony.

EXPANDING HEALTH INSURANCE COVERAGE

BACKGROUND PAPER FOR A HEARING BEFORE THE SENATE COMMITTEE ON FINANCE
CHAIRED BY SENATOR JOHN HEINZ
JUNE 30, 1988

OVERVIEW

37 million Americans do not have health insurance coverage. This lack of coverage discourages or prevents access to needed medical care. It also shifts the cost of care to others in ways that are burdensome and inequitable. Rapidly rising medical costs are not only contributing to the growing problem of the uninsured, they also increase the financial pressures on employer and government health insurance plans.

The causes of uninsurance are many and varied. No single factor accounts for the whole problem, and no single legislative proposal is likely to solve it. Employment provides the major source of health insurance for most families -- over 80 percent of the workforce is currently insured. However, all employers do not provide their employees health insurance, and 62 percent of people without health insurance are in families where the primary worker has steady employment. The lowest rates of coverage are in small businesses -- only 33 percent of the workers in firms with fewer than 10 employees are covered by their employer's health plan.

Many of the uninsured do not have a strong enough attachment to the workforce to gain employer-provided health coverage. This includes chronically unemployed workers, parents out of the workforce with child care responsibilities, part-time and seasonal workers, and early retirees who are not yet eligible for Medicare. However, only 13 percent are in families where no member worked at all during the year. Young workers are the least likely to have coverage -- 22 percent of those age 18 to 24 are without health insurance.

Poverty and youth are particularly significant factors related to lack of insurance. Three-fourths of the uninsured between the ages of 18 and 64 earn less than twice the poverty level. Nearly 40 percent of poverty families have no health insurance coverage. Children under 18 also have very low rates of coverage -- 20 percent are without insurance -- nearly one out of every three uninsured persons is a child under age 22 living with a parent.

Since 1979, the uninsured population has increased by 30 percent. A number of factors may account for the rise in the number of uninsured. One significant factor is the shrinking role of the Medicaid program. The average income for eligibility for Medicaid declined from 71 percent to 48 percent of the poverty level between 1974 and 1986. Changes in the nature of employment have also contributed to the growth in the uninsured. In the early 1980s, the economic recession increased unemployment and early retirement rates, eroding health coverage. In addition, the rising proportion of service-sector jobs and non-union jobs in the economy has contributed to a stagnation in the growth of employee benefit plans. Finally, the tendency in insurance to reduce premiums by improving the selection of low risk individuals may also be contributing to the increasing difficulty individuals in high-risk categories or with pre-existing conditions may have in getting insurance.

Lack of health insurance is a serious impediment to the utilization of health care services. The uninsured are more likely than the insured to defer seeking care or be denied care because they do not have a means to pay for the care. The deferral of care may eventually compound the medical problems and result in more intensive and costly medical care in the end.

Lack of health insurance is also contributing to a growing burden on hospitals and other health care providers of uncompensated care. Currently, about $7 billion a year in hospital charges (5 percent of total charges) is not reimbursed. In public hospitals, where the problem is greatest, an average of 12 percent of total charges are unreimbursed. Uncompensated care drives hospitals to either cutback on services to reduce overall costs, or shift some of the costs to other charge-payors. In some cases, hospitals are making decisions on service delivery and patient care driven by financial concerns over the cost of uncompensated care.

Solutions to the problem of the uninsured should address all three factors that contribute to the lack of health insurance. First, health insurance is not universally available at an affordable price to individuals. Second, not all individuals can afford to purchase health insurance, no matter what the price. Third, were health insurance available and affordable, there would always be individuals unwilling to purchase it, preferring instead to remain exposed to the risk of catastrophic loss.

Options for expanding coverage run the gamut from expansions in Medicaid to mandating that health insurance be provided by all employers. Some options propose a restructuring of health insurance to increase the availability and reduce the cost of insurance to small groups and individuals, usually by pooling and subsidizing high risk individuals and groups. Other options would encourage or require all employers to provide group insurance to their employees. A third set of options would permit low-wage individuals to buy-in to Medicaid through the use of sliding scale premiums. Some variations of a number of these options may need to be combined to resolve the problem of the uninsured.

HEALTH INSURANCE COVERAGE

- 202 million Americans had health insurance coverage throughout 1986. 26 million were age 65 and older and were covered under Medicare, with 20 million of these also covered under another health insurance plan (Medicaid, employer-provided plan, or individual Medigap insurance).
- 174 million Americans with health insurance throughout 1986 were under age 65, most of these covered through their employer. They were covered as follows:
    - 137 million in employer plans (65%)
    - 24 million in other health insurance (11%)
    - 17 million in Medicaid (8%)
    - 9 million in CHAMPUS (4%)
    - 3 million in Medicare (1%)
- 37 million people under age 65 -- 17 percent of those under 65 -- lacked health insurance coverage at some point during 1986.

REASONS FOR LACK OF COVERAGE

- Employer does not provide insurance: Most uncovered are in families with a steady worker who does not get health insurance coverage from their employer:
    - 62 percent of the uninsured (21.7 million) were in families in which the primary family worker was steadily employed throughout the year.
    - Of this group, most (18.2 million) were in families in which the primary worker works full-time. Only 2.8 million were in the families of part-time workers.

- Many of those who work and are not covered are employed by small firms and/or in the service sector of the economy.
  - Small firms have low rates of coverage. Only 51 percent of workers in firms with fewer than 100 employees are covered by their employer's health plan. Coverage rates are lowest among the smallest firms -- only 33 percent for those in firms of less than 10 employees.
  - Small firms that are incorporated or that have been in business for a number of years are more likely to offer health benefits than unincorporated or recently established firms of comparable size.
  - A 1986 survey by the Small Business Administration found that retail trade, services and construction firms offer health plans at significantly lower rates than other industries. The workforce in these firms includes high percentages of part-time, seasonal, young, and highly mobile workers.

o Marginal employment or unemployment: Some uninsured do not have a strong enough employment connection to get employer-provided insurance:

  - 13.5 percent of the uninsured (4.7 million persons) were in families where no member worked during the year.
  - Part-time and occasional workers and their dependents are more than twice as likely as full-time, steadily employed workers to lack health coverage. 32.2 percent of persons in the families of steady part-time workers and 30.6 percent of persons in the families of occasional workers do not have health insurance.
  - Eligibility waiting periods limit participation by seasonal and temporary workers in employer-sponsored health plans. Nearly 20 percent of employer-sponsored health plans have waiting period of 4 or more months.

o Youth: The age groups with the lowest rates of coverage are children and young adults.

  - Young adults have the lowest rates of health coverage. 22 percent of those age 18-24 do not have health insurance. Young people entering the workforce often elect out of employer-provided health benefits or do not purchase private insurance because of their relatively low health risk and limited disposable incomes.
  - Children who are not of working age also have low rates of coverage. 20 percent of persons under 18 do not have health insurance. This may result either because primary workers with families have lower rates of coverage than single workers, or because some primary workers with families do not elect dependent coverage due to higher cost.

o Low Income: The poorest families have the greatest risk of being uninsured.

  - More than one-third (38.0 percent) of the persons with family incomes below the poverty level have no health insurance coverage.

  - Among workers age 18-64 without health insurance coverage, one half (8.3 million) earn less than 125 percent of the minimum wage. Over three-fourths (12.8 million) earn less than 200 percent of the minimum wage.

- o Uninsurability: Some of the uninsured have health conditions which make insurance expensive or unavailable.

  - The American Medical Association estimates that about 1 million people are unable to obtain insurance in the private market because of poor health status, previous medical history, or employment in a medically hazardous occupation.

  - The number of persons who are "high-risk" is much greater than the number who are actually uninsured for this reason. Persons with a history of medical problems may be able to obtain coverage under employer group policies that they may be unable to obtain as an individual or through a small group.

COVERAGE TRENDS

- o A growing proportion of the population is uninsured.

  - The number of non-aged persons without health insurance has increased by 30 percent since 1979 -- from 28 to 37 million between 1979 and 1986.

  - An increasing proportion of the population is uninsured - 15 percent in 1979, 18 percent in 1986.

- o Increases in the uninsured result from shrinkage in Medicaid, economic recession, shifts in employment, rising health insurance costs, increasing competition in marketing insurance.

  - Medicaid has shrunk because eligible categories have been fixed and revenues limited. The average eligibility level for Medicaid has declined from 71 percent of the poverty level in 1975 to 48 percent in 1986.

  - The 1981-82 recession caused a drop (in the two years following) in the percent of workers covered by employer plans from 78 to 76 percent - the number of workers without employer coverage increased by 18 percent and the number of workers without coverage of any kind increased by 23 percent.

  - The service sector, with the lowest rates of health coverage, has been the fastest growing sector of the economy - manufacturing, with the highest rates of coverage, has been stagnant. From 1970 to 1982, services gained 8.2 million jobs, while manufacturing lost 400,000 jobs.

  - A Decline in Dependent Coverage has resulted in an increase in the number of uncovered individuals in families with a covered worker. Between 1979 and 1986, the proportion of persons covered by another family member's policy decreased from 34 percent to 31 percent.

  - Rapidly rising medical costs have made health insurance a more expensive employee benefit - the medical care costs have increased by 127 percent in the last decade.

- Alterations in rating practices have been used to keep premiums low and to compete in attracting low risk enrollees. High risk groups and individuals are being rated out of the market. Commercial insurers continue to rate on the basis of actual group experience - attracting low risk and rejecting or setting high rates for high risk groups and individuals. Blue Cross/Blue Shield and HMOs have changed, or are trying to change, rating practices in order to compete.

PROBLEMS OF THE UNINSURED

o The uninsured do not receive good health care.

- Uninsured delay or defer needed care more often than do the insured.

  -- A 1983 Louis Harris poll found that 14 percent of all families reported unmet needs. The rate for the uninsured was nearly 33 percent.

  -- A 1986 telephone survey by the Robert Wood Johnson Foundation found that when compared to the insured, the uninsured:

    -- are almost twice as likely to be without a regular source of health care;
    -- are 27 percent more likely to have not had an ambulatory visit within the past 12 months;
    -- have a slightly higher rate of medical emergencies;
    -- are less likely to be hospitalized; and,
    -- are more than twice as likely to be dissatisfied with the medical care they did receive.

  -- A 1987 GAO study found that uninsured women began care for a pregnancy later with fewer physician visits than insured women -- citing lack of money as the main barrier to seeking earlier or more frequent care.

- Care for the uninsured tends to be urgent or emergency care.

  -- Non-emergency care goes primarily to insured patients, especially high technology care. Unsponsored care tends to be for emergencies: maternity and neonatal care, and treatment of accidental injuries.

  -- In a 1983 study at Vanderbilt Hospital, nursery, pediatrics, and Ob/Gyn accounted for 42 percent of charity and bad debt cases, and 47 percent of unpaid charges. The mean unpaid bill was $2,884. However, 2 percent of the non-paying patients had bills of $25,000 or more, accounting for 35 percent of the total uncompensated care.

  -- Young adults have the highest rates of uninsurance. This group is more likely to need maternal care and accidental injury care than it is to need complex treatment for serious illness. Poor mothers are more likely to have high-risk, high-cost pregnancies.

- o Someone else pays the bill for the uninsured.
  - Sponsored care is subsidized by the public:
    - -- State/local hospital subsidy -- $2.3 billion - 1984.
      - -- the subsidy declined from 51 percent of operating costs in 1980 to 42 percent in 1984.
      - -- free care comprises more than 30 percent of the budget of the average public hospital, as compared to about 3 percent on average for hospitals in the private sector.
    - -- Other Public Funding (Fiscal Year 1984)
      - -- Neighborhood clinics with public grants
      - -- Veterans medical care ($7 billion)
      - -- Maternal & Child Services ($0.3 billion)
      - -- Childhood Immunization ($30 million)
      - -- Other federal, state and local programs
    - -- Private Charities -- ($9 billion in 1983)
  - Unsponsored Care is not reimbursed.
    - -- Unsponsored Hospital Care -- $7 billion in 1986. it rose as a percentage of total hospital costs from 3.6 percent in 1980 to 5 percent in 1986. An estimated 68 percent of hospital "bad debts" are due to uninsured patients.
    - -- Unsponsored Care by Non-Hospital Sources -- A 1982 survey of physicians found that 77 percent provided some free or reduced fee care - total practice billings were reduced by 9 percent as a result of the provision of charity care (total of $9 million per year, $16,000 per physician)
- o It is inequitable for other insurance plans to pay for the uninsured.
  - Hospitals include indirect costs of bad debt and charity care in charges to some private payors.
    - -- Medicare and Medicaid reimburse for little or no unsponsored care.
    - -- 1982 Urban Institute study found that commercial insurers paid 27 percent more, and Blue Cross paid 17 percent more than average cost; while Medicare paid average cost, and Medicaid paid 10 percent less than average cost.
    - -- Hospitals charge private payors an estimated 10 percent surcharge to recover uncompensated care costs.
  - Hospitals that cannot recover all uncompensated care costs from other payors may cut costs, consume surpluses or refuse charity care.
  - Hospitals may minimize losses by denying care to uninsured patients.

OPTIONS FOR EXPANDING COVERAGE

o Increase the availability/reduce the cost of health insurance:

Two approaches aim at creating large pools of individuals either to make health insurance available to high risk individuals who would otherwise be denied, or to lower the cost of insurance to individuals or small groups.

One approach would regulate or encourage insurance companies to offer community-rated policies to individuals and small groups. This would provide lower the cost of insurance to high risk individuals/groups by spreading the cost of this insurance across lower risk individuals/groups who would otherwise pay lower premiums. An alternative approach is to require insurers to reinsure high risk individuals or groups -- which would also have the effect of pooling the risk.

An alternative approach would establish State or regional government-sponsored pools, to make insurance available to individuals or small groups at a uniform cost. One variation on this in use now in 15 States is the high-risk pool. These pools limit their insurance to individuals who would otherwise be unable to purchase insurance at a reasonable cost. Individuals pay a premium, usually capped at 150% of the average individual premium for the State. Excess losses in the State pools are subsidized through taxes on insurance or through other tax revenues.

o Encourage or require employers to provide health insurance to their employees.

Most people now get health insurance coverage through an employer plan, and most of the uninsured are in families with a steady work connection. State or Federal laws could either encourage employers without plans to adopt health insurance through tax incentives or require that employers provide health insurance as a condition of employment.

Most proposals to expand employer coverage involve two stages: 1) establishing a minimum health benefit standard (to define what a health insurance plan is), and 2) setting incentives or penalties to encourage adoption of a plan.

Incentives would include a variety of unique tax benefits (special tax credits for small busines or expanded deductibility for the self-employed) to reduce the net cost of a health insurance plan for an employer.

Penalties or mandates would either impose a tax on employers that would be rebated or offset by the cost of a health insurance plan, or establish civil or monetary penalties for failure to adopt a plan meeting the minimum standards. The health benefit mandate recently enacted in Massachusetts would establish a minimum cost for health insurance. Employers providing benefits costing less would pay the difference to a State fund providing insurance to the uninsured. Employers with no benefits would pay a fixed fee to the fund. S. 1265, introduced by Senator Kennedy in 1987, would require a health plan under the Fair Labor Standards Act - and impose a monetary penalty equal to 10 percent of wages for non-compliance.

o Expand Medicaid

Currently, fewer than half of the poor can qualify for Medicaid. Proposals to expand Medicaid eligibility usually involve the use of a "buy-in". Under a buy-in, individuals would be able to purchase coverage for a sliding scale premium based on income.

o Reimburse providers for uncompensated care

Governmental units could subsidize providers directly for the costs of uncompensated care and finance this cost with a tax on all payors or the general population. While this approach would be effective in reducing the burden of uncompensated care on providers, it would not necessarily improve access to care for medical indigents.

OPTIONS FOR FINANCING EXPANDED COVERAGE

Any proposal to cover the uninsured will either redistribute costs or require additional funding. Revenue-raising options are numerous, ranging from payroll taxes to user fees to lotteries. Decisions regarding appropriateness of revenue sources must be based on several important considerations:

- To what extent should the revenue source be tied to health?
  Some sources (taxes on cigarettes and alcohol, hospital profit taxes, copayments for Medicaid services, etc.) are directly connected to health or medical services. Health-related sources may prove easier to justify politically, but are limited in number. They may also affect health care costs or coverage.

- Who should pay?
  Should costs fall on employers, employees, insurers, providers of care, or society at large? Should states or the federal government bear the larger burden? Should those of greater means face greater costs? The most critical issues include:

  Degree of re-distribution: Our current health care system redistributes costs -- from healthy to sick in health insurance, from young to old in Medicare and retiree health care plans. To what extent should the redistribution be increased or reduced. Should the sick or those with higher risk pay more? Should redistibution be based on health status, age, geography, service concentration.

  Mix of Federal and State financing: Medicare and Medicaid are all or largely Federally funded. States and local governments finance public health programs and public hospitals. States are also becoming more active in financing efforts to expand health insurance, including risk pools and mandated employer benefits. However, States have varying size populations and ability to tax and may have difficulty implementing pooling or coverage proposals. Federal approaches would provide greater uniformity but less adaptation to local circumstances.

- Federal Financing Options

  In addition to standard revenue sources, there are a number of options that relate the tax to health or health benefits:

  - Modify or eliminate tax deductibility of health benefits
  - Increase "sin" taxes on products that create health problems
  - Tax labor through payroll taxes or mandating benefits
  - Tax illness/health providers
  - Increase cost sharing for health services or public insurance

- State Approaches to Financing Indigent Care

  - State and county taxes
  - Expanding Medicaid eligibility to increase Federal share
  - One-time grants to establish trust funds

- Hospital assessments
- Conditions for granting certificates of need
- Allowing indigent care buy-ins
- Earmarked lottery funds

PENDING FEDERAL LEGISLATION

S.1265/H.R.2508 (Kennedy/Waxman)

The "Minimum Health Benefits for All Workers Act" sets up a Federal standard package of health benefits and requires all employers to provide that plan, or something that is actuarially equivalent, to all workers above 17 1/2 hours per week. A limited exemption for very small businesses and family farms will be phased out over time. The bill sets up regional pools, through which a few carriers would provide insurance to firms of 25 or fewer.

S.1139/H.R.3580 (Chafee/Lagomarsino)

The "MedAmerica Act" expands the Medicaid program by allowing States to expand coverage in 3 ways: 1) cover everyone up to the poverty line, regardless of eligibility for AFDC or SSI; 2) allow those between 100-200% of poverty to buy Medicaid on a sliding scale basis; and 3) allow those above 200% of poverty to buy Medicaid at full price.

Stark Risk Pool Proposal

As proposed in '87 Reconciliation and Catastrophic, this provision would set up guidelines for a "Federally qualified" risk pool, which States would have the option to adopt. These pools would offer a standard benefit package, and be open to any uninsured resident, not just the high risk "uninsurable". A Federal excise tax, equal to 5 percent of payroll, would be imposed on any large employer who did not contribute to the pool's losses.

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BACKGROUND

UNINSURED IN PENNSYLVANIA

The Pennsylvania General Assembly passed legislation in 1986 setting up the "Pennsylvania Health Care Cost Containment Council" to study the problem of the uninsured and recommend legislative solutions. The Council is required to submit its final legislative recommendations on July 1, 1988, and the General Assembly has 120 days under the Act to either enact the plan as submitted or some modified/substitute package. The Council has held a series of public hearings and collected the viewpoints of diverse interests. In addition, the Council has commissioned a study of the uninsured by Lewin/ICF which finds:

1.2 million Pennsylvanians are uninsured (8.6 percent of the total population, 12.9 percent of the under-65 population).

- 25% are below the Federal poverty line, only 3% live above 200% of poverty.
- 1/3 of the low-income uninsured are children.
- The uninsured make up 14.6% of the population in Pittsburgh, but only 6.3% of the population in Philadelphia.
- Although the number of uninsured in PA peaked during the recession and is now back down to 1980 levels, the number of employed uninsured is on the increase.

700-800,000 Pennsylvanians are underinsured (i.e., they have public or private coverage which leaves them exposed to high out-of-pocket costs -- too high to be adequately met by their income).

The survey did find that the percentage of persons who are uninsured is lower in PA than in most other states because:

- PA covers several optional populations under Medicaid.
- Blue Cross's community-rated plans, make individual and small group coverage more affordable than in most other States. (Blue Cross of W. PA found that 69% of the individuals in their community rated plans are below 150% of poverty.)

Access to primary care is a problem for many of the uninsured of PA. These persons are:

- More likely to be without a regular source of primary care
- More dependent on hospital-based sources of care, especially emergency rooms
- Twice as likely to be refused care for financial reasons
- Often unable to obtain referrals for specialty care

PA's uninsured tend to defer/postpone care, which results in poorer health status.

There are differences in the availability of indigent care among the geographic regions of the State. Rural areas, where over 1/2 of the uninsured live, have particularly acute access problems.

While hospital emergency room care is generally available, many uninsured have difficulty obtaining hospital care for non-life-threatening conditions.

Financing and commitment of providers for care of the medically indigents is not stable.

- Although hospital care for the medically indigent has been evenly distributed in the past, there is growing unevenness in the Pittsburgh and Philadelphia areas. This competitive pressure strains the resources of those hospitals providing the bulk of uncompensated care, and can reduce their ability to serve this population in the long run.

- Although the percent of bad debt/charity care provided by PA hospitals (3.6%) is lower than the national average (5.7%), this type of care is on the increase.

- Physicians and organized primary care are in short supply in some parts of the State (e.g. certain rural areas). In other places (e.g. Philadelphia), services are available, but delivery is fragmented and less accessible to minorities.

MEDICAL ASSISTANCE:

Pennsylvania provides medical assistance to needy individuals through Medicaid and additional State indigent care programs. For Pennsylvania in FY87-88, the budget for all medical assistance programs was $2.24 billion which included a Federal match of $1.09 billion.

Medicaid - Is a Federal-State program enacted in 1965 to provide medical assistance to individuals eligible for Federal and Federal/State income assistance programs and other low-income individuals.

In every State, most individuals who are eligible for public assistance (e.g. AFDC or SSI), along with those waived into the program, are considered "categorically eligible." States may optionally expand categorical eligibility to pick up: families with unemployed parents, pregnant women with no children, children and pregnant women in two-parent families that are income eligible, pregnant women with children with incomes up to 160 percent of the poverty level. Pennsylvania has elected to pick up nearly all of the optional categories. Medicaid coverage is extended for 4 to 9 months (Pennsylvania opts to extend another 6 months) to those on welfare who go back to work but do not make enough money to pay for their own health insurance. Those who would lose eligibility because of child support payments can continue to receive medical assistance for up to 4 months after they go off the rolls.

In addition, States may elect to cover individuals who are "medically needy". Individuals are "medically needy" if their medical expenses will reduce their resources to the State eligibility level. "Medically needy" programs are available in 31 States (including Pennsylvania). "Green cards" are issued in Pennsylvania to medically needy only (MNO) individuals. The green card covers only physician costs, hospital charges and long-term care, with an exception granted to school children in need of dental care.

In addition, Pennsylvania has an optional Medicaid waiver to provide home and community-based services to mentally retarded children and high-tech children (Michael Dallas). A second home and community-based service program for ventilator dependent children (Katie Beckett-type) is operated and financed by the State.

Since 1980, the amount of money the State of Pennsylvania has spent on Medicaid has increase at a level slightly higher than that of the United States government.

Total Medicaid Expenditures - FY 1980-1985 (in billions of dollars)

	FY 1980 Expenditures	FY 1985 Expenditures	% Growth
PA	$ 1.1	$ 1.8	70%
US	$23.3	$37.5	61%

Pennsylvania's General Assistance - Medical Program

Pennsylvania provides State-financed medical assistance to individuals who do not qualify for Medicaid, but meet state income eligibility standards. Individuals with incomes below $379-469 (or below $89[illegible]-1012 for a family of four) and with assets below $250 ($1000 for a family of four) may qualify for medical assistance. In addition, physically disabled adults not on SSI, mentally ill adults who are unemployable, eligible persons 45 and over, persons employed 30 or more hours with incomes below medical assistance benefit levels, and persons with lengthy work histories who have exhausted unemployment benefits may also qualify for medical assistance. In fiscal year 87-88, Pennsylvania spent $1.2 billion on General Assistance-Medical.

Since July 1, 1984, Pennslyvania has also provided Pharmeceutical Care for the Elderly. In order to qualify for the program, a person must be 65 or older, a state resident eligible for public assistance and have an annual income of less than $12,000 or less than $15,000 for a married couple. The program covers all legend drugs, insulin and insulin supllies. Participants must make a co-payment of $4 for each prescription. The state funds this program through the state lottery program. In the first year of the program the state budgeted $115.6 million for FY85-86, but officials expected to spend only $60-70 million.

PRIVATE GROUP AND INDIVIDUAL INSURANCE

o Health insurance is provided by a complex assortment of insuring entities, including the following:

-- Commercial plans that offer employers traditional indemnity plans that reimburse subscribers a set fee for services received.

-- Self insured plans whereby companies assume the risk of paying employees' medical bills instead of purchasing insurance coverage. (The percent of employers that self-insure has more than doubled over the past decade, from 19% in 1979 to 40% in 1987.)

-- Health Maintenance Organizations (HMOs) which provide comprehensive services in exchange for a prepaid, monthly fee.

-- Preferred provider organizations (PPOs), a term that applies to a many arrangements by which health providers contract directly with groups of employers or through an intermediary to offer reduced rates for services.

-- Blue Cross/Blue Shield plans which offers 77 different funding and services arrangements to 78 million subscribers, 85% of whom are non-elderly group enrollers. In general, the "Blues" contract with providers and pay them an agreed rate for each service delivered.

o Individuals who are not associated with a group can also obtain health insurance by purchasing "individual" coverage directly from an insurer, but at usually higher cost.

-- About 14.5 million non-Medicare individuals are enrolled as individuals in non-group policies. Commercial insurers cover the majority, the "Blues" insure over 4 million and HMOs enroll about 1 million.

INSURER	ENROLLEES (in millions)	PERCENT
Commercial insurers	9.3	64%
Blue Cross/Blue Shield	4.2	29%
HMOs	1.0	7%

o How insurers determine rates

-- Community-rating -- the same rate is charged to all members, spreading costs for the entire group evenly and averaging the costs of poor health risks.

-- Experience-rating -- the previous claims experienced by a particular group is used to determine rates for that group. Usually, this rating choice is used by larger groups when past experience is likely to be reliable.

-- In order to remain competitive, insurers that once used only community-rating now use experience-rating for large group populations, and have priced their premiums to reflect the actual experience of the groups they are insuring.

o Criteria for participation in insured plans

- -- Underwriting is the process by which an insurer determines whether or not, and under what conditions, an applicant is accepted. With some exceptions, insurers seek to limit the losses associated with high-risk applicants by identifying such applicants and, if applicants are accepted, modify the rates and/or terms of the insurance contact.

- -- Benefits typically excluded from plans may be for services associated with any "pre-existing condition." Almost without exception, insurance policies that are not employment-related require a "waiting period" before coverage is effective for any health condition that existed prior to enrollment. (However, all services related to an illness or injury, other than the pre-existing condition, are covered during this waiting period.)

- -- Health plans (except federally qualified HMOs) may reject an individual or small group if risk is judged to be too great, either because of the health status of the prospective enrollee or because of the probability that the group will not pay the premiums. (Federal law precludes federally qualified HMOs that offer small group coverage from rejecting individuals based on pre-exiting health conditions. For this reason, some HMOs will not offer coverage to small groups.)

- -- Large groups of enrollees represent the best risk for an insurer; small groups may have only a few individuals electing coverage, and those most likely to elect coverage are those who are most likely to be in need of insurance. Individuals seeking non-group coverage (individual policies) are most likely to use health services.

o Limiting plan costs

- -- The escalating cost of health care in the U.S., at rates far above inflation, has heightened the incentives for all payors -- employers, governments, and insurers -- to reduce their payments.

- -- Common mechanisms to control plan costs include:

  - -- requiring enrollee to share directly in the cost of covered services through deductibles (i.e., the enrollee is required to pay an initial amount for services before the carrier begins to pay) and coinsurance (i.e., the enrollee is required to pay a portion of the cost of those covered services received).

  - -- restricting utilization of certain health care services, especially relatively expensive treatments. In some health plans, such as HMOs, the insurers limit services because the carrier provides or arranges services directly for enrollees; other plans require that health care providers meet certain criteria prior to reimbursement for services or require a mandatory second opinion.

  - -- controlling reimbursement costs by negotiating "discount rates" with hospitals/doctors at lower than their average charges for these services and at rates set specifically for the insurer's enrollees.

PENNSYLVANIA
PUBLIC INTEREST
COALITION

Penn PIC, NORTHEAST CHAPTER
19 North River Street
Sterling Annex
Wilkes-Barre, Pa. 18701
717/824-1716

June 30, 1988

TESTIMONY OF THE PENNSYLVANIA PUBLIC INTEREST COALITION BEFORE U.S. SENATOR JOHN HEINZ

Good morning. I'm Curt Hules, the Northeast Regional Director of the Pennsylvania Public Interest Coalition (PennPIC), the state's largest consumer lobby organization. On behalf of 15,000 PennPIC members in Northeastern Pennsylvania as well as 110,000 PennPIC members across the Commonwealth, I bid you welcome to Wilkes-Barre.

I'm here to reiterate what PennPIC and many employers, labor organizations, civic associations, health care providers and leading newspapers have already said: America can no longer afford to stand by and watch tens of millions of working, productive families live in fear because they have no or inadequate health care insurance.

PennPIC has joined the national effort to pass S. 1265, the Minimum Health Care Bill, because it is unconscionable for America, the richest and most technologically advanced country in the world, to turn its head while so many of its workers cannot provide basic health care for themselves and their families.

This growing crisis needs to be addressed immediately. To continue to ignore the problem will only weaken America's competitiveness with strong western nations which already see the necessity and benefit from the advantages of a healthy workforce, a workforce that doesn't have to live with the emotional stress related to what can happen if illness strikes.

Despite the predictable arguments from the limited business sector which chooses not to provide its employees with health care benefits, employee wellness makes good business sense. A fit worker is a productive worker.

We applaud Senator Edward Kennedy and his staff for going the extra mile to make S. 1265 affordable for businesses that are contributing to our growing national health problem. Provisions in the Minimum Health Care Bill will assure a smooth transition into employee health care coverage for employers who currently argue that they cannot afford it.

For businesses that can afford to provide health care benefits but choose not to, S. 1265 is simple justice: the legislation will require them to provide benefits comparable to their more reasonable competitors. They no longer will be able to pass employee health care costs along to their employees and, ultimately, the rest of society.

For businesses that now provide health care insurance at the work place, the Minimum Health Care Bill will reinforce their progressive policy by ensuring a more fair system of competition which will require ALL businesses to provide at least a minimum health care package for their workers.

No one can deny that America's greatest economic resource is a Healthy, productive, loyal workforce. S. 1265 will guarantee that we continue to have that resource in the future. Thank you.

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HEALTH CARE FOR THE UNINSURED

By: Richard P. Lafleur, M.D.
June 28, 1988

Health Care for the uninsured patient is becoming one of the more prevalent problems in our society. There has been repeated references made to this in many Medical Journals in the press and in political circles. This ranges from appropriate coverage for caring for the elderly under the Medicare system, but more importantly in the patient without any method of payment. This is discussed in regards to catastrophic illness for someone that is uninsured, but the issue is more involved and more extensive.

I am presently a practicing physician under the Public Health Service, employed by the Rural Health Corporation of PA and in the two years of my employment this issue has become an increasing problem as there has been more Federal cutbacks to Organizations, such as, the Rural Health Corporation. Rural Health Corporation serves a population that is 64% Medicare, 16% Medical Assistance, only 6% as an insured population and the remaining 14% is an uninsured population. It is this 14% of our population which has become more an issue at this point in time. As Federal cutbacks increase, the capabilities of Organizations such as Rural Health to care for these patients becomes more strained. There are many problems involved with the care of these patients and are more than just a catastrophic illness which can be devastating to both the patient and the Health Care System.

In previous years when the DRG System was not as prevalent these patients for evaluation and treatment could be admitted to the hospital and the health care costs were shared between the hospital and the physician without reimbursement. However, the DRG System has created an increasing difficulty for obtaining studies and appropriate tests as these patients can no longer be admitted to the hospital for evaluation unless extremely ill because the hospitals are having more difficulty meeting unreimbursed costs. The major problems that the physicians face when seeing patients without insurance is not that the patient cannot pay for the visit, but more so the frustration that is faced with convincing the patient to pay for these certain procedures or tests that is needed for their overall health. The cost for these patients although may seem minor is quite expensive for the individual. In a sense over the last few years we have seen more patients not seeing physicians until the problem has become so extensive or so painful that they then present to the Emergency Room. At this point it may be too late. I will outline three aspects of the care of patients who are uninsured in regards to appropriate care.

The first problem is the one already mentioned and that is the patient neglecting himself because of cost and presenting to the Emergency Room with life threatening or catastrophic type illness that requires extensive medical and technological management. The second is the case of the patient who presents to the Emergency Room with a problem and a hospital admission is necessary. Hospital costs can be high even for the shortest admission and the patient understanding this problem finds himself in a situation that if they stay they will have extensive medical bills to pay and if they leave prior to completion of care the medical bills will be substantially reduced, however, the care is only of limited value. From my experience thus far, I have seen that this has been the major deciding factor and the patients frequently will leave prior to completed care. Subsequently, there may be further medical illness or with some luck the patient may improve on their own. The last issue is in regards to preventative health for the uninsured. This, I believe, is the root of the problem. The insured patient presents to the physician for routine medical care and evaluative tests and receives appropriate preventative health screening to identify problems before they can occur. However, the uninsured patient is not given that opportunity. He may see the physician who may do the screening physical exam, however, Laboratory work such as Complete Blood Count, Urinalysis is unable to be complete because of the patients inability to pay for these costs. More specifically, Mammograms which could possibly identify early carcinoma of the breast and with early appropriate limited treatment extensive medical costs could be prevented. There are many other issues involved with Preventative Health Care in the sense of prevention of illnesses or treatment of them prior to the illness becoming quite extensive. This situation creates a two scale health care system. One group who could afford a standard of health care and the second group who cannot and therefore is under the fate of the particular illness.

The situations that I have faced revolve around having the patient understand the reason for having preventative health care type tests done. The patient is usually not agreeable to having this evaluation done simply on the basis of the costs that it would entail. I have not had any specific problem obtaining appropriate specialty consultation or tests in someone with a particular illness. However, this is not the case throughout the country. I must say that I have been quite fortunate to work in an area that all the physicians are quite helpful and willing to see these specific patients at my request. In regards to payment for a particular evaluative test done as an outpatient, I have been fortunate to have a health care staff from secretary to nurses who are capable of finding finances through outside agencies. However, these are far and few between and creates an extensive burden on my staff and in the sense serves the individual patient, however, does not serve the greatest quantity.

There are many issues revolving around health care of the uninsured, many solutions are posed, many commitaries are written, but still no answers. I think from a physician standpoint, I have not found that there are physicians unwilling to care for the uninsured, but is more the sense that they find the situation quite difficult and frustrating mainly because of the difficulty of obtaining tests, specialty consultations and appropriate follow-up care. Specifically, this was referenced to an article in December 4, 1987 titled "Unconscious on a Corner." In this situation the patient was agressively treated, however, upon discharge the patient was sent back to the situation that he was in prior to the hospitalization. These issues involve more than just physician interest and willingness to care for the poor; it is an issue of our entire society to offer reasonable options and reimbursement methods for hospital and physicians.

Testimony of Joan McNaney

My name is Joan McNaney. I live in Bucks County, Pennsylvania with my husband and 3 children. I am not employed. My husband works on his father's farm. He does not have health insurance coverage there. Since there are only 2 employees (plus my father-in-law) we are not eligible for group rates. We pay rates for individuals, and the insurance does not cover any regular doctor visits. Therefore, in addition to our insurance premium, we still pay about $1,500 per year for doctor visits and prescriptions.

We have always had health insurance, but in 1984, when our premiums were $2,600 per year, we decided to change insurance companies, as this was about 10 percent of our income. In '85 and '86, our premiums were $1,172 per year, which were more manageable on my husband's salary. We thought we were getting the same coverage, but came to find out that our insurance company would pay only part of the doctors bills, and a maximum of $5,000 for a hospital stay.

We found this out in December of 1986 when our eldest son, Bill, then 12, developed hydrocephalus, or fluid on the brain. He went to St. Christopher's in Philadelphia. Bill was in the hospital for 8 days. He had brain surgery to insert a shunt and had dozens of tests done to find the cause. The hospital stay cost $15,549. The insurance company paid $5,000, leaving us with a balance of $10,549. In addition to the hospital bill, the doctors' bills were about $10,000. We came to an agreement with the hospital that we would pay them back $200 per month -- that's what we do when we have the $200 to pay. They send us letters to remind us each time we miss a payment. Our outstanding balance is still over $5,000.

Our insurance bills for 1987 were $3,000. This is more than 10 percent of my husband's income. We changed insurance companies, but still had to keep 2 of our sons on the old policy due to the fact that the new company would not cover any pre-existing illnesses for the first year of the policy. Due to the price increase in insurance premiums, we will pay $3,000 again this year for health care coverage and as I said before, we still have to pay the everyday doctor bills. I have looked into other insurance companies, like HMOs, but they will not accept individuals or even our small farm group.

It doesn't seem fair that employees of small businesses cannot afford to pay the premiums for health insurance coverage, but yet cannot get the group rates.

Statement of
THE HOSPITAL ASSOCIATION OF PENNSYLVANIA
to the
SENATE COMMITTEE ON FINANCE
SUBCOMMITTEE ON HEALTH
June 30, 1988

Mr. Chairman and members and staff of the Special Committee on Aging, my name is Jim Redmond and I am Executive Vice President of The Hospital Association of Pennsylvania, which represents some 260 general acute care and specialty hospitals in the Commonwealth. I appreciate this opportunity to appear before you to discuss health care for the medically indigent.

It is frequently assumed that every American in need of medical care should have access to it regardless of ability to pay. Just what constitutes "need" in this context or who should pay is usually left unsaid. Our preoccupation with health care cost containment is creating a growing problem of access to care for many of our citizens.

One of the most comprehensive studies on health care for the medically indigent was recently completed in Pennsylvania.[1] Some of the most significant findings include the following:

OVER ONE MILLION PERSONS IN PENNSYLVANIA, OR ABOUT 8.6 PERCENT OF THE POPULATION, HAVE NO PUBLIC OR PRIVATE HEALTH INSURANCE.

- Over 70 percent of the uninsured have incomes below 150 percent of the poverty level, or about $16,800 for a family of four.
- Over one-half of all uninsured adults are employed.
- Over one-third of the low income uninsured are children.
- Rates of uninsurance vary by region. The Pittsburgh area

(10.6 percent) has a particularly high rate of uninsurance compared to Philadelphia (8.6 percent).

- The uninsured have poorer health status than the insured.

MANY EMPLOYERS DO NOT OFFER HEALTH BENEFITS

- Well over one-half of the firms with fewer than five employees offer no health care coverage. Over one-third of firms with five to nine employees offer no health care coverage.
- Over 90 percent of small firms that offer insurance to full-time employees do not extend the coverage to their part-time employees.
- Over 17 percent of small firms do not extend the coverage to dependents of employees.

PENNSYLVANIA'S MEDICAL ASSISTANCE PROGRAM (MEDICAID) IS NOT DESIGNED TO COVER ALL OF THE POOR.

- Only 50 to 60 percent of those below 150 percent of poverty are covered.
- Only three-fourths of those eligible for Medicaid are enrolled.

THE MEDICALLY INDIGENT FACE BARRIERS IN THE USE OF HEALTH SERVICES.

- The uninsured are more likely to be without a usual source of care.
- The uninsured are more likely to be dependent upon hospital-based sources of care.
- The uninsured report difficulty in obtaining needed care.
- The medically indigent tend to defer or postpone seeking health care services.

ACCESS FOR THE MEDICALLY INDIGENT TO OBTAIN EMERGENCY MEDICAL CARE OR INPATIENT CARE FOR ACUTE, NONDEFERRABLE CONDITIONS APPEARS GENERALLY AND WIDELY AVAILABLE.

The extent to which the medically indigent will receive adequate and timely health care depends upon the financial capacity and commitment of health care providers. Hospitals provide charity care for both inpatients and outpatients. This care is financed primarily through cross-subsidies from privately insured patients. It is also supported by private philanthropy and some government grants and appropriations. The Hospital Research Foundation estimates that hospitals in Pennsylvania will provide approximately $450 million of uncompensated care at cost this fiscal year. This does not include approximately $170 million in payments from Medical Assistance that are less than actual costs. Much of the care provided to the uninsured and underinsured are paid by employers and employees who are insured. This method of financing forces businesses to subsidize the care provided to employees of businesses who do not provide insurance.

There is danger that the traditional methods of financing care to the medically indigent will erode in Pennsylvania. As competition and cost containment efforts increase, hospitals will be less able to serve the uninsured and underinsured.

Faced with the need to stabilize or lower prices to their charge-paying patients, hospitals must either lower their operating margins or reduce their uncompensated care. Otherwise, they risk losing privately insured patients to other facilities. Hospitals with high uncompensated care levels can be at an unfair competitive disadvantage in the face of price competition. Access to hospital care will become affected if these hospitals begin to limit care to the medically indigent. Hospitals that continue to serve the uninsured could become financially weakened.

The Hospital Association of Pennsylvania recommends the state and federal governments should resolve the issues of medical indigency by taking the following steps:

1. Maximize Medicaid coverage by:
   - enhancing eligibility standards to the maximum levels permitted under federal law;
   - establishing mechanisms to enroll the maximum number of those eligible for benefits; and
   - increasing payment rates to approximate the cost of providing care.
2. Maximize the use of private health insurance by:
   - encouraging employers to provide health insurance with appropriate participation by employees, dependents and retirees;
   - creating incentives such as tax credits for employers, especially small business employers, to provide health insurance coverage;
   - encouraging the purchase of insurance coverage by individuals and families who do not have employer-sponsored coverage; and
   - making it easier to continue coverage after job loss.
3. Develop special programs targeted to serve high risk groups such as pregnant teenagers, AIDS patients, children, migrant workers, mentally ill, chemically dependent, and the homeless by:
   - establishing more effective primary and preventive care arrangements; and
   - contracting with major providers to perform essential services.

It is generally accepted that the United States has the best health care system in the world. Yet alongside our success, there are beginnings of a disturbing future for our health care system. If access to health care for a growing number of Americans continues to be limited, our health care system and our society will significantly change. Failure to address this issue will result in a further worsening of the problem. Employers and employees currently paying for health insurance cannot continue to subsidize those who do not. Hospitals with high volumes of uninsured and underinsured patients face competitive pressures that undermine their commitment to serve their communities. Most importantly, many Americans face financial barriers that force them to forego necessary care or place them at substantial financial risk if serious illness or injury strike.

Today, we have an opportunity to solve a problem and in the end help millions of Americans. We have the knowledge to make a differnce. The question is: Do we have the commitment? The Hospital Association of Pennsylvania is ready to commit to you, Senator, and the Committee, our help and resources in this endeavor.

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[1] Pennsylvania Health Care Cost Containment Council, "Health Care for the Medically Indigent in Pennsylvania," Lewin and Associates, Inc., January 14, 1988.

Pennsylvania's Declaration
of Health Care Information
A Commitment to
Quality, Affordable,
Health Care

ACT
89

PENNSYLVANIA HEALTH CARE
COST CONTAINMENT COUNCIL

Ernest J. Sessa
Executive Direct

PURSUANT TO SECTION 8 (d) OF THE HEALTH CARE COST CONTAINMENT ACT, THE HEALTH CARE COST CONTAINMENT COUNCIL SUBMITS THE FOLLOWING REPORT TO THE GOVERNOR AND GENERAL ASSEMBLY OF THE COMMONWEALTH OF PENNSYLVANIA.

HEALTHY PEOPLE AND EFFICIENT HEALTH CARE: A PRIORITY FOR PENNSYLVANIA.

July 1, 1988

Ernest J. Sessa
Ernest J. Sessa
Executive Director

SECTION I BACKGROUND/PROCESS

A. Legal Framework for the Proposed Plan

Act 89, The Health Care Cost Containment Act, is designed "to promote the public interest by encouraging the development of competitive health care services in which health care costs are contained and to assure that all citizens have reasonable access to quality health care." Specifically, Section 8 "a" of the Act, in a declaration of policy by the General Assembly, "finds that every person in the Commonwealth should receive timely and appropriate health services from any provider operating in this Commonwealth; that, as a continuing condition of licensure, each provider should offer and provide medically necessary, lifesaving and emergency health care services to every person in this Commonwealth, regardless of financial status or ability to pay." Access to reasonable care for every Pennsylvania resident is therefore raised to the level of public policy of the Commonwealth, within the framework of competitive health care purchasing through comparative cost/quality data prepared by and disseminated through the Health Care Cost Containment Council.
Concerned with reducing the undue burden on providers who may disproportionately treat medically indigent people on an uncompensated basis, and to those who may disproportionately pay through cost shifting, Act 89 (Section 8 "b") mandates a study of the medically indigent population, defining the problem and its magnitude; providing solutions to the access problem; and developing a plan for an ongoing program of indigent care for the Commonwealth.

Act 89,(Section 3) defines Indigent Care as "The actual costs, as determined by the Council, for the provision of appropriate health care, on an inpatient or outpatient basis, given to individuals who cannot pay for their care because they are above the medical assistance eligibility levels and have no health insurance or other financial resources which can cover their health care."

Act 89,(Section 8 "d") requires the Council submit its plan to the Governor and General Assembly on or before July 1, 1988, with the General Assembly having an additional 120 days after the Council's submission to (1) enact the Council's Plan as submitted; (2) modify and enact the Plan; or (3) enact a substitute indigent care program.

B. Why Access to Health Care is Essential for Pennsylvania

1. The Health Consequences

Our State's medically indigent are over two million Pennsylvanians who have either no health insurance, or coverage that is inadequate to ensure timely and appropriate health care.

They are: pregnant women unable to afford adequate, or often any pre-natal care. Today, Pennsylvania's infant mortality rate exceeds that of the nation, with infants of non-white and poor parents much more likely to die than their more affluent and white counterparts.

Pennsylvania's medically indigent and children who go without needed medical treatment because their parents cannot afford health coverage for them. For these children and others, this neglect can mean shortened lifetimes of marginal health.

They are the disabled and the elderly, who because of their health status are unable to obtain insurance through employment and cannot afford it on their own.

These persons, our neighbors, suffer from restricted access to needed health care. They use health services at a more advanced stage of illness, because they postpone critically needed attention, unable to obtain, or too proud to accept care they cannot afford. When emergency and acute care is finally sought, it may be too late to reverse what could have been corrected if diagnosed and treated earlier. The most classic examples are those who do not obtain care for diabetes or hypertension until suffering permanent, lifelong and expensive illness.

Adequate health care protection is something that approximately twenty-five percent of all our residents do not have.

2. The Economic Consequences

There is harm beyond that of severely limiting access to health care for those among us who are least able to obtain it. The present manner we finance health care services to the medically indigent has an adverse economic impact upon consumers, purchasers and providers.

a. Consumers

Over one million Pennsylvanians, or about 8.6 percent of the total population, have no public or private health insurance. Many of these persons are the "working poor," with incomes or assets too high to qualify for Medical Assistance but too low to purchase private health insurance. Over 70% of the uninsured have incomes below

150% of the poverty level, or about $17,475 for a family of four. Uninsured children are of particular concern because of the need for ongoing preventive and primary care. About 36% of the low income uninsured are under the age of 17.

The Medical Assistance program covers only 50 to 60 percent of those individuals below 150% of poverty. About 1.2 million persons are covered by the program, but another 700,000 of the poor are without health insurance. One reason for this is that Medical Assistance in Pennsylvania has not kept pace with cost of living. In 1970 98% of those eligible for AFDC and thus eligible for Medical Assistance were below the federal poverty level. Today only 51% of those below the federal poverty level are covered.

For some, particularly those in the upper income brackets, the lack of coverage may be a matter of personal choice. For many of the working poor, insurance is simply not available through their employers, and the cost of purchasing an individual insurance plan is prohibitive.

These individuals and families are at risk of incurring substantial out-of-pocket expenses for health care. They also face financial barriers to care and may postpone or forego needed medical attention as a result. This population also relies more heavily upon hospital emergency departments with greater cost and less continuity of care.

b. Purchasers

Study data indicate that hospitals will provide approximately $450 million of charity/bad debt at cost this fiscal year. This does not include approximately $170 million in loss of payments from Medical Assistance that are less than actual costs. It also does not include care provided by other health care providers to the uninsured and underinsured.

The payment of this $620 million of unreimbursed care is cross subsidized and paid by private insurers, and ultimately by employers and employees who are insured. This method of financing forces businesses to subsidize the care provided to employees of businesses who do not provide insurance and forces unionized workers to face disadvantages with nonunionized workers for bargaining health insurance coverage for themselves and their families. The long term consequences of financing indigent care in this manner can lead to restricted economic growth and loss of new job opportunities in the Commonwealth.

c. Providers

The extent to which the medically indigent receive adequate and timely health care depends substantially on the financial capacity and commitment of health care providers. Currently, a wide range of health care providers in the Commonwealth serve the medically indigent care at no or reduced charges.

There is a danger that the traditional methods of financing care to the medically indigent will erode in Pennsylvania. As competition and cost containment efforts increase, some health care providers, such as hospitals, physicians, and primary health care centers, will be less willing or able to serve the uninsured. Faced with the need to stabilize or lower prices to fully insured or paying patients, health care providers find that they must either lower operating margins or reduce their uncompensated care. Otherwise, they risk losing privately insured patients to other health care providers who do not provide services to the uninsured and underinsured.

Hospitals with high uncompensated care levels can be at an unfair competitive disadvantage in the face of price competition. Access to hospital care will become affected if these hospitals begin to limit care to the uninsured. Hospitals that continue to serve the uninsured will become financially weakened.

Failure to address this issue will result in a further worsening of the problem. Employers and employees currently paying for health insurance cannot continue to subsidize those that do not. Health care providers with high volumes of uninsured and underinsured patients face competitive pressures that undermine their commitment to serve their communities. Finally, and most importantly, many Pennsylvanians face financial barriers that force them to forego necessary care or place them at substantial financial risk if serious illness or injury strike.

C. Council's Contracted Study

Pursuant to Section 8 "c" of the Act, the Council, through a competitive bid process, awarded a contract for conducting the Indigent Care Study to Lewin and Associates, Inc. ("Lewin"), a Washington, D.C. consulting firm, experienced in similar studies for several other states and the Federal Government. The contract period started June 1, 1987. Although Lewin submitted a final report to the Council on June 28, 1988, several additional data studies by Lewin are not due to be completed until September 15, 1988. These studies include a computer modeling of the economic impact on employers, unions and consumers, of various program initiatives to provide health care to the medically indigent and retention of an independent actuary to conduct actuarial studies to measure precise costs associated with such initiatives.

Section 8 of the Health Care Cost Containment Act also requires that the Council's report on the medically indigent reflect input from all interested parties.

In meeting that input requirement, the Indigent Care Committee of the Council ("Committee") sought the active involvement of interested and expert persons and groups in the Commonwealth, i.e., health care providers, insurers, business, labor, consumers, state officials, and indigent persons themselves. Representatives of the Departments of Public Welfare, Health and Insurance; staff to legislative committees; personnel from the Governor's Budget Office; representatives of purchasers, including business and labor, insurers, hospitals, physicians and other health professionals, HMOs and primary care centers; and especially, representatives of the medically indigent, the homeless, the unemployed and other consumer groups participated in the more than twenty (20) meetings of the Committee.

In addition to the Committee meetings, the interim reports by Lewin were distributed to over 500 individuals and organizations along with information on how to comment on these reports.

- Eleven (11) public hearings were held throughout the Commonwealth. The first series of three hearings focused on defining and describing the actual phenomenon of indigent care and accepted formal, public testimony from 56 presenters. Additional written comments were offered by individuals and organizations.

  The second series of eight hearings focused on potential solutions to the problem of medical indigency and heard formal testimony from 94 presenters with additional written comments by 57 others.

- Lewin conducted a series of structured personal or telephone interviews with more than 80 public and private policymakers, providers, insurers, business people, labor representatives, consumers, and government officials to solicit necessary detail about the medically indigent and solutions.

- Lewin developed and conducted two surveys to gather more specific and measurable information in particular areas of concern.

- Finally, Lewin conducted a literature search for reports of other states' experiences with indigent care studies or programs; reviewed and assessed the potential impact of other federal and state programs on any potential indigent care program; and conducted a review of the current Pennsylvania Medical Assistance Program.

- Lewin made its principals and staff available for 12 public meetings where they answered questions, explained methodology and offered tentative findings and conclusions.

The program initiatives contained within this report thus reflect the wide variety of alternative strategies for providing health care to Pennsylvania's medically indigent presented to the Council through its extensive outreach efforts.

SECTION II DESCRIPTION OF PENNSYLVANIA'S MEDICALLY INDIGENT POPULATION

After analysis and review of the Lewin analytical and draft reports, the Council has determined that Pennsylvania's medically indigent population can be described as follows:

1. One out of every four Pennsylvanians have either no health insurance or coverage that is inadequate to ensure timely and appropriate health care. Over 1 million Pennsylvanians do not have health insurance either public or private. Another 700-800,000 have limited insurance. An additional 1.2 million MA enrollees have limited access.

About 2/3 of the uninsured are either employed or the dependents of the employed. The uninsured are also young (12.6% ages 5 or below; 28.7% under age 17.) The uninsured are also low income (about 70% are at or below 150% of the poverty level; 78.3% are at or below 200% of the poverty level.)

Many of the uninsured lack the financial capacity to pay fully for insurance if offered by employers.

2. While the employer is the primary source of non-elderly insurance coverage in the country, (nearly 80% non elderly insured persons in the country are covered by an employer plan) not all Pennsylvania employers offer health insurance to employees, especially small employers. (less than 1% of firms employing 100+ employees, do not offer health insurance; 39% of firms employing 5-9 do not; 54% with 3-4 do not; and 66% with 2 or less do not.)

Most firms sampled do not offer insurance to part-time employees.

3. Pennsylvania has experienced a shift in economic development from manufacturing to retail and service sector jobs which are less likely to offer health benefits. The number of uninsured in Pennsylvania (1,221,000) was approximately the same as in 1980 (1,234,000) although the unemployment rate dropped reflecting the employment shift to firms not offering insurance.

The expected continuing trend to retail and service sector employers who do not offer health insurance will increase the number of uninsured in Pennsylvania in future years.

4. Many of the uninsured and underinsured lack access to timely and appropriate primary and preventive care. These services are essential to all Pennsylvanians. They are the gateway to health care and to efficient use of health resources.

The uninsured are more likely to be without a usual source of care; are more likely to have gone 1 year since the last medical visit; and are less likely to use a private doctor's office. The uninsured often delay or forego health care, resulting in increased risk of developing more serious conditions which are more expensive to treat (pre-natal care and hypertension are two examples). The uninsured also rely more heavily on hospital emergency departments with greater cost and less continuity of care than do those with private insurance.

Delaying medical care and seeking ambulatory care in hospital emergency departments also cause inefficiencies in the health care system. In addition, the uninsured and some Medical Assistance populations (green card) face financial barriers in obtaining needed prescription drugs, resulting in interruption or abandonment of a desired treatment plan.

5. Financial and competitive pressures will likely reduce care offered to the medically indigent.

Study data (1980-85) indicated that hospital bad debt/charity loads were within the bounds of many other states and were evenly distributed throughout the Commonwealth. There was no significant correlation to bad debt/charity burden and hospital operating margins. During the study period, hospital operating margins peaked in 1985 at 4.97 percent. Since that time, operating margins have fallen to 3.4 percent in 1987 and projected to fall even farther during the next several years. This decline in operating margins may force many hospitals to limit charity care. Hospitals with high indigent care volume will find themselves at a competitive price disadvantage and may lessen their capacity to maintain services to the uninsured.

Additionally, the ability of many providers to shift costs of uncompensated care to traditional sources, such as business and private payers, is severely curtailed by Pennsylvania's strategy of encouraging economic competition in health care. In short, especially in light of existing Federal Medicare and State MA underpayments to hospitals and other providers and expected tightened Federal reimbursement, the current system for furnishing indigent care is inherently unstable. Failure to broaden accessibility to health care could continue the unnecessary death and disabilities of our citizens, will penalize providers who conscientiously serve the uninsured and will continue the cost shift which distorts economic relations in Pennsylvania.

SECTION III PROGRAM INITIATIVES/OPTIONS TO PROVIDE HEALTH CARE FOR PENNSYLVANIA'S MEDICALLY INDIGENT

No single program will solve Pennsylvania's health care access problem. Instead the solution involves many initiatives in both public and private sectors. These efforts will take several years to fully implement. We are presenting a full listing of these programs for consideration by the Legislature, combining a mixture of expanded insurance and service initiatives.

In developing program initiatives, the Council established the following criteria:

- Universal access to medical care by the medically indigent should be timely and appropriate.
- Providing care to the medically indigent should be a public/private partnership.
- All participants in the health care/delivery system should play a role in providing care to the medically indigent.
- The current health delivery system should be continued with a minimum amount of intrusion.
- The current employer based health insurance system should be continued and expanded.
- The Medical Assistance system should be continued and expanded to the maximum allowed by Federal law as appropriate.
- State-of-the-art health care cost containment procedures should be incorporated into all program initiatives.
- All program initiatives should encourage the development of quality health care delivery and relate to the Council's cost/quality comparative data mandate.
- All program initiatives should ensure equitable distribution of the delivery and cost of providing care to the medically indigent among all providers of health care services, the Commonwealth, employers and individual citizens.

- Service delivery mechanisms should be tailored to local conditions and meet appropriate standards.
- All program initiatives should provide a coordinated, ongoing primary care system for the medically indigent.

Utilizing the preceding criteria, the Council presents to the Governor and General Assembly, a series of program initiatives designed to provide effective and quality health care to Pennsylvania's medically indigent. These program initiatives, containing both service and insurance initiatives, are grouped into four categories of interrelated programs.

- Employer Based Insurance
- Special Non-Group Insurance
- Medical Assistance
- Service Expansion

Both insurance and service initiatives are crucial to ensure the quality of health care provided to Pennsylvania's medically indigent because:

- The proposed insurance initiatives, while expected to cover many additional people, would still leave a significant number of Pennsylvania's citizens uninsured.
- Many of the newly insured will remain uninsured for specific services (e.g., prescription drugs, dental care, well-baby visits) and will need a service system in place to provide those services.
- Since many of the low income newly insured will confront deductibles and coinsurance that may make access to care costly and difficult, the availability of care on a reduced fee basis may be a critical factor in these families obtaining timely care.
- Having insurance does not necessarily guarantee that the services are in place or that services are accessible. This is especially true for certain mental health and chronic conditions, for AIDS patients, for the homeless, and even for certain types of services such as prenatal care.

SECTION IV EMPLOYER-BASED INSURANCE

The Council reviewed and debated a variety of approaches to expanding employer-based insurance. The Council is including for consideration two alternative proposals, and will continue to research other alternatives, including the data and process implications from the independent actuarial studies now underway.

Although the Council could not agree on the best alternative at this time, the Council did agree to the following principles:

1. The Plan must encourage employers to provide adequate health care for employees and dependents.

2. Both the employer and employee should contribute to the cost of the premium.

3. The Plan must be consistent with the Employee Retirement Income Security Act (ERISA).

Imposition of mandatory insurance, defined benefits, actuarial equivalent/value, are all ERISA considerations being further researched by the Council. That research, along with the actuarial studies, will be submitted as a formal amendment to this Program Initiative by October 15, 1988. The insurance proposal adopted by the Commonwealth must provide a workable process by which an employer can measure existing benefits offered against any actuarial standards adopted or other comparative measure.

4. The Plan must monitor cost shifting to ensure appropriate distribution of the indigent care responsibility.

5. Mechanisms for cost containment/cost efficiency must be essential components of all Plans, including but not limited to managed care, selective contracting, use of generic drugs. The Council emphasizes that use of Council cost/quality comparative data will be an effective tool in prudent purchasing of insurance by employers and consumer.

The Alternative approaches offered by the Council for employer-based insurance, are herein included:

A. ALTERNATIVE A

Incentives for Employer Based Insurance

. Premise is to build on employer based insurance.

. Legislative incentives will be created to expand employer financed insurance. Under this program, employer financing will be expanded to cover employee/dependents. If an employer chooses not to use incentives, employees will be able to purchase non-employer affordable insurance.

. Actuarial studies are being conducted to" rate" or cost the original benefit package proposed by Lewin, estimated by Lewin at $1500. Those studies will be available by mid-July.

. A reasonable cap will be placed on the cost of any recommended plan, if the actuarial study should be considerably higher than the Lewin estimate.

. Employee Retirement Income Security Act (ERISA), based on Council study appears to prohibit a defined benefit plan being proposed and may prohibit an actuarial value/equivalent provision. ERISA, we believe, requires the Commonwealth to create strong incentives for expanding employer based insurance, instead of mandating. ERISA issues are being researched legally. Other alternatives to a defined benefit plan are also being reviewed.

An actuarial equivalent process offers flexibility to employers for benefit mix, but loses emphasis on a benefit thrust for primary care.

Program Initiative Description:

. Employee is defined as 30 hrs. per week the first year of the program's implementation; 26 hrs. year 2; 22 hrs, year 3; and 18 hrs. thereafter;

- Dependents will also be phased in on a comparable scale;
- An employee must be employed for 4 consecutive months to be eligible;
- No Medical underwriting on pre-existing condition clauses;
- Subsidies will be available for firms defined as financially vulnerable;
- Employers will certify those eligible employees who are covered elsewhere and thus not a responsibility;
- Employer may opt to purchase a Managed Group Insurance Coverage (MGIC) Plan which will be available and incorporating cost efficiency/containment principles; (See page 30 for MGIC description)
- Financially vulnerable firms will be required to participate in the MGIC Plan.

Administration:

- A designated lead agency will be responsible for implementing the program.

Exhibit 1
HOW DOES THE PLAN COVER THE ONE MILLION UNINSURED IN PENNSYLVANIA?*

- Medical Assistance Expansion**145,000
- New Insurance Coverage
  - Employer-based plans 220,000
  - Individual plans 100,000
- Community Health Services Program (number shown is for uninsured only; service strategies also cover underinsured, Medical Assistance, and some insured populations) 185,000
- Persons who are assumed to remain uninsured and continue relationship with existing provider. 150,000 persons who are assumed to be eligible but remain uninsured.

Total Persons under 200 Percent of Poverty*** 800,000

- Non-poor uninsured population, some of whom will purchase new employer plan; others of whom can generally afford and obtain care. 220,000

TOTAL 1,020,000

* These estimates are approximations based on a series of assumptions. They are presented for purposes of assessing and debating the program initiatives and will be further refined when actuarial and economic impact studies are completed.

** This total, and the accompanying cost estimates, include three MA groups that are already scheduled for inclusion in the program as of April 1, 1988, and subsequent phase-in dates: pregnant women and children up to age five under the poverty level. Elderly/disabled, to the poverty level, are also included in the Governor's proposed budget for January 1989 inclusion.

*** 200 percent of poverty is $23,300 for a family of four.

B. ALTERNATIVE B

Incentives for Employer Based Insurance

(ERISA issues and actuarial studies listed on Employer Based Insurance through Alternative A also apply to this Plan.)

- Premise is to build on employer based insurance;
- Employer will participate financially in insuring only employees/dependents who are above the Medical Assistance eligibility level and below 200% of the poverty level;
- Employees must notify the employer of desire to be insured; if the employee does so, the employer is required to provide insurance;
- The employee contributes a percentage of total wages to the premium cost. The balance is shared by the employer and Commonwealth, with the Commonwealth portion funded through general revenues;
- Managed care is the service vehicle, with care outside the managed care providers or beyond the managed care rates paid by the employee;
- Employers will certify those eligible employees who are covered elsewhere and thus not a responsibility.

C. MANAGED GROUP INSURANCE COVERAGE (MGIC)

Description:

- The MGIC would satisfy the actuarial equivalent requirement of any employer-based initiative.
- MGIC, as offered by all insurers, HMOs, risk-bearing PPOs, hospital service plans and health service plans, would be certified by the state as meeting the requirements of the act, specifically including cost containment provisions such as second surgical opinions, preadmission testing, utilization review and use of generic drugs.
- A system of designated providers would be established.

  -- To be "designated" under MGIC, providers must demonstrate that they can offer case management, such as referral to inpatient care, specialty care, and follow-up care.

  --Beneficiaries would be required to pay a higher cost-share if they choose to obtain care from a provider who is not "designated" under MGIC.

- Financially vulnerable employers who receive financial assistance from the state in purchasing employee health coverage must purchase the MGIC product.

Insurance carrier incentives to offer MGIC:

- All insurers, HMOs, risk-bearing PPOs, hospital service plans and health service plans shall be required to offer MGIC. Employers would be free to buy insurance from any carrier offering this coverage.
- Employer-based insurance plans offered under the Indigent Care Plan, by HMOs, hospital service plans and health service plans (Act 61 and 63) subject to rate regulation by the Insurance Department rated by an independent actuarial consultant and containing a statement that the rates established are actuarially adequate premium rates will be exempted from the rate review procedures of the Insurance Department, except for Section 5 of the Casualty and Surety Rate Review Act.
- By requiring financially vulnerable firms to purchase MGIC, insurers have an incentive to sell the MGIC product.
- Because the state would certify MGIC plans as meeting efficiency standards, insurers could use this certification as a marketing advantage in selling this product to non-financially vulnerable employers
- Pennsylvania-based multiple employer trusts would be encouraged by the state Insurance Department in efforts to foster development and offering of the MGIC product.
- MGIC would be fully coordinated with the Department of Public Welfare so as to encourage joint venture public/private efforts to increase workplace based insurance.

Cost sharing and premiums:

- Separate deductibles for individuals and families.
- Maximum annual limits for individuals and families.
- No deductibles or copayments for prenatal care and well-baby care.
- Copayment for prescription drugs and on all other services.
- Subsidized employers who are required to make insurance available with no employee contribution to the premium for employees and their families whose income is less than 125 percent of poverty.
- A set maximum premium share for employees.
- Arrangements would be made to accommodate level employer contributions in multiple choice plans by allowing these ceilings to apply only to the lowest actuarially qualifying plan.

D. REINSURANCE

- The legislature should consider establishing a reinsurance mechanism to spread the risk of high-risk beneficiaries among all insurers offering small group coverage and providing for no medical underwriting of individual risks.

E. SMALL BUSINESS OPPORTUNITIES

- The Council will convene an advisory committee of small employers (less than 10 employees) to periodically review barriers to insurance development for small employers.

F. SEASONAL EMPLOYEES:

- The Council is undertaking a study of the special characteristics of industries which rely on seasonal employees in an effort to determine the most economic method to provide coverage to such workers and the differences within each industry.
- The results of this additional study will be submitted by October 15, 1988.

G. CAFETERIA BENEFITS:

There has been significant concern about the impact of cafeteria benefit plans on employer qualification for tax credits. We therefore are proposing a special study of this issue by the Council.

SECTION V SPECIAL NON-GROUP INSURANCE PRODUCT (SNIP)

For individuals/families not covered by an Employer Plan
Estimated enrollees--100,000 current uninsured

Description:

- SNIP would be available to all uninsured individuals and their families not covered by an employer-based plan.
- SNIP would be community-rated with no exclusions because of health status and no pre-existing condition restrictions.
- Blue Cross and Blue Shield would be required to create SNIP.
- Legislation would establish a maximum loss ratio of 100 percent (to include administrative costs, marketing costs, and direct intended subsidies) for SNIP.

Benefits:

- Outpatient visits and services including prenatal care, well-baby care and preventive care. Limit of one preventive visit per person per year.
- SNIP would cover a limited number (e.g., 5) of hospital days with the expectation that hospitals would treat days beyond the covered period as eligible for charity care consistent with financial assessment

standard and as contribution toward Medical Assistance spenddown.

- Prescription drug coverage
- Cost sharing:
    - No deductible for individuals and families below 200 percent of poverty.
    - Separate deductible for individuals and for families above 200 percent of poverty.
    - No deductible for prenatal care, well-baby care and immunizations.
    - Copayment for prescription drugs. Could include contract prescription drug service with no copayment for low income populations.

Participant costs and Fee Schedules:

- Premium costs would be income-related based upon the following income limits:
    - Full premiums for persons above 200 percent of poverty.
    - 50 percent of the full premium for individuals and families between 150 and 200 percent of poverty.
    - 25 percent of the full premium for individuals and families below 150 percent of poverty.
- Income-related premiums require income determination upon enrollment and annually thereafter.
- Physician fee schedules will be set with full allowance for those above 200 percent of poverty and a discounted allowance for those below 200 percent of poverty.
- Hospital payments will be not less than costs incurred for patient care services.

Administration

- The insurance Department would have oversight for the program, to be reviewed at least annually.
- Blue Cross/Blue Shield would be responsible for administering and marketing the plan.
- An independent outside actuary chosen by the Insurance Department and Blue Cross/Blue Shield would be responsible for determining pure premium, administrative and marketing costs for all program elements.

Financing:

- Blue Shield participating physicians, Blue Cross participating hospitals, HMOs and those community health centers receiving state funding would be required to accept the SNIP fee as payment in full for beneficiaries within the designated income limits.

- Agreements with hospitals to admit low income patients under SNIP with regard to hospital stays beyond five days as charity care for MA spenddown consistent with hospital financial assessments.
- The difference between the actuarially determined premium with the above assumptions and the designed income-related premium would be subsidized by the Trust Fund.
- Blue Cross/Blue Shield maximum loss ratios (to include administrative costs, marketing costs and direct intended subsidies) to be 100 percent.

Contingencies which may have an impact on final SNIP design:

1. Independent actuarial studies now underway include the following areas:

   a) Costing or rating of SNIP as proposed on a service/market area basis to determine geographic variations in health care costs, and total

      statewide costs of the SNIP program.

   b) Estimate of administrative and marketing costs.
   c) Estimates of individual participants' premium contributions and premium subsidy required from the Trust Fund.

   d) Consideration of alternative approaches for the SNIP program, i.e., risk-taking vs. administrative services-only contracting.

   e) Costing of a range of benefit plans that could be offered on a subsidized basis.

2. A consideration of the efficiency of an existing discounted Blue Cross/Blue Shield product as an alternative to SNIP as described here.

3. A joint examination by the Insurance Department, Health Department and Blue Cross/Blue Shield of existing losses in order to better focus intended subsidies on programs for the indigent.

SECTION VI. MEDICAL ASSISTANCE EXPANSION

A. Potential Options

There are several areas where Pennsylvania can expand the Medical Assistance Program to cover currently uninsured, indigent Pennsylvanians. This will enable us to share with the Federal Government the cost of insurance coverage. Those potential areas are outlined on exhibit 2

There are additional recommendations regarding assistance for Pennsylvanians qualifying for Medical Assistance "spenddown" coverage, improved relations with providers and increased citizen access and cost containment which can be considered.

B. Medical Assistance/HMOs

The Health Care Cost Containment Council recognizes the use of health maintenance organizations (HMOs) within the Medical Assistance Program to provide Medical

Assistance recipients with accessible, high-quality and cost effective care. Voluntary enrollment of recipients in HMOs places such recipients in an environment which encourages disease prevention, prompt diagnosis and treatment under the overall guidance of a recipient-selected personal primary care physician, with formal quality of care oversight and grievance resolution systems.

The Council, likewise, recognizes the potential use of less structured managed care systems, such as preferred provider organizations (PPOs). PPOs provide recipients with greater freedom of provider choice and less provider risk-assumption, based upon careful selection of participating providers, and show some promise of both better service recipients and generating cost savings through cost effective practice of quality medicine and ability to negotiate volume discounts with selected cost-effective, quality providers.

The Council recommends that the Office of Medical Assistance identify and address perceived HMO barriers to serving the Medical Assistance population. The Council further recommends that once such perceived barriers are identified and resolved to the best of the ability of the Office of Medical Assistance within the constraints of state and federal law governing the operation of prepayment programs, that HMOs which do not enroll Medicaid recipients be subject to appropriate state sanctions.

The Council also recommends that the Office of Medical Assistance use the cost and quality data to be made available by the Council.

C. Medical Assistance Shortfall

Medical Assistance shortfall, that is, the difference between a provider's cost and Medical Assistance payment, is a problem which must be resolved in order to insure access to care and establish a level playing field for competitive buying and marketing of services.

Hospital Association of Pennsylvania (HAP) estimates a 1987 MA shortfall of $86.1 million on the inpatient side and $80.5 million on the outpatient side.

Physician participation in the MA program remains an access problem, due to reimbursement regarded by physicians as less than adequate, combined with cash flow and unwieldy claim procedures.

The Council acknowledges the access problem and competitive barrier because of the Medical Assistance shortfall and recommends the following:

1. Institute a claims processing system more user/friendly to providers.

2. The Legislature through a joint resolution, assign responsibility to a standing or special committee, to develop a minimum reimbursement floor for all Pennsylvania providers in a non-inflationary indexing system, with the committee work completed within the 120 day period in which Act 89 requires the Legislature to act on the Council's Plan submission.

3. Placing priority on increasing payment for primary care, obstetrics, and prevention services,

using economic incentives to encourage increased participation of providers of health care.

4. Implementation of disproportionate rate adjustment for hospitals with a high volume of MA patients.

D. Other Non-Medical Assistance Recommendations

In addition to these MA recommendations, the Council also recommends the following for consideration:

1. Support legislation promoting use of generic drugs as a cost containment vehicle for all programs offering prescription coverage.

2. The Health Department should insure that all Pennsylvania children be immunized against childhood infections.

3. The Health Department should supply free vaccine to all who would not receive it in a timely fashion.

4. The Legislature should consider continuity of care and physician liability concerns in development of state provided free vaccine.

EXHIBIT 2

POTENTIAL EXPANSIONS OF MEDICAL ASSISTANCE
(See Appendix for Detail)

.Implement efforts to expand enrollment for persons currently eligible or potentially eligible for MA.

-Place eligible workers in hospitals (financed by hospitals

-Place eligible workers in or rotate them through primary care centers

-Hire outreach workers to visit employment agencies, social service agencies, schools, and other locations where there are likely to be potentially eligible persons.

-Develop manuals and technical assistance efforts on eligibility for providers and patient advocates.

-Implement educational/promotional effort on new eligibility categories.

-Implement transition requirements to assist persons who lose MA in obtaining individual insurance product described in next section, including:

1) Require notification upon termination of MA; and
2) Assistance to clients with application procedures.

.Expand eligibility to all additional groups that can be added to the program under Federal law.

-Raise Medically Needy threshold to 133 percent of the AFDC standard for each region and for each family size. (Federal law allows the Medically Needy standard to be set at 133 percent of the state's AFDC standard. In Pennsylvania, the standard is below level for several regions and family sizes.)

* -Cover pregnant women (for pregnancy-related services) and infants up to 185 percent of poverty. Require persons between 150 percent and 185 percent of poverty to pay a modest premium. Require no resource standards. (Note: The Commonwealth currently covers these groups up to the poverty level.

** -Cover children through age eight under the poverty level, phased in by age until all age groups are covered by 1991. Require no resources standards. (Note: The Commonwealth currently covers some of these age groups or plans to cover some on a phased-in basis; this proposal is set for the maximum age allowed by federal law.

*** -Cover aged and disabled up to the poverty level. Require no resource standards.

-Cover for a full 15 months allowed under federal law, families who lose eligibility for Aid to Families with Dependent Children (AFDC), and hence MA, due to the expiration of work incentive disregards in the AFDC program.

.Enhance services available through MA by:

-Adding prescription drug and dental coverage to the Medically Needy population.

-Increasing Early Periodic Screening, Diagnosis, and Treatment Program for Children (EDSD) standards to march standards of the American Academy of Pediatrics.

.Implement a work incentive insurance program for persons who earn their way off MA.

-Program should be aimed at persons who risk losing their MA as they take a job or obtain increased wages.

-Build on the experience of the job training insurance demonstration project currently being implemented by the Department of Public Welfare for a small group of training recipients.

-For a designated time period, pay the full premium of the individual insurance plan described in later sections, or provide continued MA coverage (with full state financing) for persons who would otherwise lose MA due to increased earnings.

-Require gradual sharing of the premium by enrollee as time passes or as wages increase.

-Explore potential for obtaining federal matching funds for persons who "spend down" by virtue of having the insurance premium paid on their behalf.

.Ensure adequate ambulatory provider participation in the program by raising payment rates for physicians, comprehensive primary care centers, and home heath care agencies.

-Monitor impact of recent fee increases to help determine level needed to encourage adequate physician participation.

-Create an all inclusive fee for comprehensive primary care centers to cover services beyond medical visit. e.g. screening, outreach care management, and supportive social services.

-In absence of above, Increase fee levels for comprehensive primary care centers by the same $5 as recently done for physicians.

-Increase Home Care Agency reimbursement

*This Plan will fund only beyond the current 100% threshold

**This Plan will fund only beyond the Age 3 coverage dated October 1, 1988 and Age 5 as already proposed by State

***This Plan will not fund these services as the Governors 1988/89 budget proposal already recommends it.

APPENDIX A

Preliminary Medical Assistance Expansion Estimates For the Pennsylvania Medically Indigent Plan[*]

	Cost (in millions)			Number of Persons Served	Methodology/Assumptions
	State	Federal	Total		
1. Enrollment of persons currently eligible for MA but not enrolled					
• Three percent increase in eligibility/outreach workers statewide (140 workers) with assumption that 50 are financed by hospitals. (90 workers @ $34,300 each)	$ 1.5	$ 1.5	$ 3.0		
DPW estimate	$ 1.5	$ 1.6	$ 3.1		
• Manuals and technical assistance; educational/promotional efforts.	0.5	0.8	1.3		
DPW estimate	0.650	0.650	1.3		
• 30,000 additional enrollees @ $1,000 per year.	15.7	14.3	30.0	30,000	• Assumes 25,000 are Medicaid eligible for federal match of 57 percent and 5,000 eligible for GA-related MA at 100 percent state funding. Per capita amount of $1,000 per year is based on $760 per "categorical recipient not receiving maintenance assistance" in FY1986 (Federal 2082 forms), projected to FY1989 with an assumed increase of 10 percent each year.
DPW estimate	21.7	16.8	38.5		
2. Expansion of eligibility to all optional groups.					
• Raise Medically Needy threshold to 133 percent of AFDC payment standard for all regions and family sizes.	6.9	8.5	15.4	12,800	• DPW estimate.
DPW estimate	5.8	7.1	12.9		

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[*] These cost estimates are preliminary, and have been developed only for purposes of modeling the impact of the indigent care plan. More refined estimates will be provided from DPW/Budget Office.

APPENDIX A
(continued)

Preliminary Medical Assistance Expansion Estimates For the Pennsylvania Medically Indigent Plan*

	Cost (in millions)			Number of Persons Served	Methodology/Assumptions
	State	Federal	Total		
• Pregnant women up to 185 percent of poverty.	8.6	11.3	19.9	9,000	• Number of persons is double the Governor's FY1989 Budget estimate of eligible pregnant women up to 100 percent of poverty. (While the difference between 185 percent and 100 percent of poverty is much greater than between the Medically Needy standard and poverty, more women above poverty will have private insurance). For costs, the Governor's Budget estimated $14.3 million in state dollars for new pregnant women and young children (up to age 3) under poverty. Assumes that $4.3 million of the $14.3 million is for pregnant women, $4 million for infants, $3 million for age 1-2, and $3 million for age 2-3. Doubling of pregnant women figure yields $8.6 million. Assumes 57 percent federal match for total cost of $19.9 million.
DPW estimate	21.4	28.3	49.7		
(Including pregnant women added as of 4/1/88)					
Current MA covers up to 100%					
Expansion is from 100% - 185% These estimates may be overstated due to inclusion of those already covered at 100%					
• Infants up to 185 percent of poverty. Includes infants added as of 4/1/88.	$ 8.0	$10.0	$18.0	$ 9,000	• Assumes number of infants is same as eligible pregnant women under 185 percent of poverty. Assumes infants under poverty account for $4 million of Governor's Budget estimate. Doubling of this number yields $8 million. Assumes 57 percent federal match for total cost of $18 million.
DPW estimate	8.7	11.6	20.3		
Current MA covers up to 100%					
Expansion is from 100% - 185%					
DPW figures include children from 0-5 at 185% poverty. This estimate my be over stated due to inclusion of those already covered at 100% Only to age 1, is 185% of poverty applicable; Rest is at 100 % and currently covered.					
• Children through age seven up to poverty.	21.0	27.8	47.8	74,000	• Governor's Budget estimated 31,700 children up to age 3 under

APPENDIX A
(continued)

Preliminary Medical Assistance Expansion Estimates For the Pennsylvania Medically Indigent Plan*

	Cost (in millions)			Number of Persons Served	Methodology/Assumptions
	State	Federal	Total		
DPW estimate	5.5	7.2	12.7		poverty. Assuming 10,600 for each year of age (31,700 / 3), the number of non-infant children up to age eight under poverty is estimated at 7 x 10,600 = 74,000. For cost, assumes $3.0 per year under poverty, from Governor's Budget estimates ($3 million x 7 years). Assumes 57 percent federal match for total costs of $48.8 million.
Governor's office plans under previous law to raise to age 5 gradually. 6 and 7 would be Lewin Lewin expansion under new law.					
• Elderly and disabled up to poverty.	2.5	3.3	5.8	18,200*	
DPW estimate	7.4	10.0	17.4		
Governor's Budget proposal includes this item as of Jan 1989 and new Medicare law requires it to be phased in. This will occur without Lewin and should be deducted ultimately from totals.					
• Premium payments from pregnant women and infants between 150 percent and 185 percent of poverty.	(0.4)	(0.6)	(1.0)		• Assumes average of $100 per year for an estimated 1,000 pregnant women and infants.
DPW estimate	.040	.040	.100		
3. Expansion of Services					
• Expand Medically Needy and GA benefits to full package (including dental and prescription drugs).	$30.7	$11.3	$42.0	--	• DPW estimate. (Program Analysis for FY 87-88)

APPENDIX A
(continued)

Preliminary Medical Assistance Expansion Estimates For the Pennsylvania Medically Indigent Plan*

	Cost (in millions)			Number of Persons Served	Methodology/Assumptions
	State	Federal	Total		
DPW estimate	28.3	10.1	38.4		
• Increase EPSDT standards (assume 0.25 additional visits per 483,000 children in MA @ $18 per visit).	0.9	1.3	2.2		
DPW estimate	0.5	0.6	1.1		
4. Implementation of work incentive health coverage program. (10,000 persons @ $1,000 person per year minus $100 per year premium).	9.0	0.0	9.0	10,000	• Assumes program can expand to at least 10,000 persons. Per per capita amount of $1,000 per year is based on $760 per "categorical recipient not receiving cash assistance" in FY1986 (Federal 2080 forms), projected to FY 1989 with an assumed increase of 10 percent each year. Assumes full state funding.
DWP estimate	0.8	.275	1.075		
5. Independent clinics fee increases	1.2	2.1	2.3		
6. Home Health agencies	1.0	0.9	1.9		
7. Administrative costs for additional eligibles, transition requirements, and work incentive program (11 percent increase in eligibles).	9.7	9.7	19.4		• Assumes administrative costs are 10 percent of program costs.
DPW estimate	18.5	13.2	31.7		
TOTAL	116.8***	102.2***	219.0***	163,000**	
DPW estimate	121.9	108.465	230.375		

APPENDIX A
(continued)

Preliminary Medical Assistance Expansion Estimates For the Pennsylvania Medically Indigent Plan*

* The cost estimates are preliminary only and have been developed only for purposes of modeling the impact of the indigent care plan.

** Total in previous exhibits is 145,000. This is the 163,000 new eligibles minus the 18,000 elderly and disabled. Because they are covered by Medicare, these populations are excluded when showing how the indigent care plan covers the one million uninsured.

*** Rounded for estimating purposes.

SECTION VII SERVICE EXPANSION:

A. The Community Health Services Program

Patients who will be enrolled in Insurance Plans through one of the new insurance offerings described in this plan, as well as those who remain uninsured, need providers available and willing to serve them. Some areas of the Commonwealth lack enough physicians, others have enough providers but lack capacity for linking people into the system (e.g., through outreach) or for coordinating diverse elements of the system (e.g., referral to specialists and then follow-up by family physicians). To address these problems, a services expansion strategy should be considered by the Legislature to complement the insurance expansion strategy.

This strategy, accomplished through the Community Health Services Program, would expand the resources available to local providers through a grant program while encouraging the development of greater efficiencies in care for the medically indigent. These efficiencies result from the designation of "qualified providers" capable of managing a patient's care for whatever health services that patient needs and of emphasizing prevention and early treatment of conditions.

Through the Community Health Services Program the state would help fund existing local health providers, or new organizations where existing providers are unwilling or unable to participate, who would directly provide or arrange access to the following services:

- o Primary and preventive services.
- o Referral to specialty and inpatient care.
- o Prescription drugs.
- o Ancillary services.
- o Case finding/outreach to bring people into the system.
- o Health education.

These grants could support the direct delivery of primary care services, outreach efforts to bring people into the system, and referrals of patients to other parts of the system, and appropriate service management in and through the coordinated system. The precise approach would depend on available local resources and organizations and the specific needs of the community. No single model of service delivery is specified; instead grants are designed to maximize flexibility and respond to the diverse needs of local communities.

1. Use of Grants

Community Health Services Grants may be used to pay for 1) primary care services (including visits to a primary care practitioner and needed ancillary services: laboratory, pharmacy, and routine diagnostic radiology) for the poor uninsured; 2) outreach, health education, and case management services for the uninsured, the insured, the underinsured, and Medical Assistance patients; 3) preventive and primary care services for the poor, especially pharmacy, that are not benefits under the new insurance products described above; and 4) expansion and limited construction and equipment for primary care centers as a last resort for use of grant funds.

2. Eligibility for Grants

Grants will be awarded to health care providers in designated areas who display the capacity to provide an organized system of primary care, including direct services in their own organizations and management of patients who require care from other providers such as inpatient hospitals. These "qualified providers" could include groups of physicians, organized primary care centers, or hospitals. While hospitals can receive the grant for primary care, they may not use the money to subsidize inpatient services.

In order to be a qualified provider under the grant program, applicants must demonstrate the following in a competitive grant application which will receive objective review by a panel consisting of state officials from the designated lead agency and outside advisors:

- Arrangements for services 24 hours a day, 7 days a week.
- Arrangements to refer patients for inpatient hospital care and specialist services. Agreements must be in writing and/or the provider must be able to demonstrate that the patients are being accepted and treated.
- Appropriate hospital privileges for all primary care physicians.
- Provision of follow-up care from the hospital and/or specialist to the patient's primary care provider.
- Access to ancillary services including laboratory, pharmacy, and radiology.
- Linkage to WIC, nutritional counseling, and social and other support services.
- Acceptance of Medical Assistance patients and the uninsured without limits, including public notice of appropriate sliding fee scales. (Sliding fee scale standards will be developed by the lead state agency and will be uniform for all grantees, with consideration given to geographic/market place differences.)
- A medical records system with arrangements for the transfer of records to the hospital, specialist, and back to the primary care physician.
- Bilingual capacity in areas where appropriate.
- Quality assurance mechanisms to evaluate the quality and appropriateness of patient care.

- Capacity for efficiency in managed care.
- Evidence of community-wide input into the design and provision of the health services.
- Supplying the state with reasonable amounts of data documenting utilization and costs in formats specified by the state.
- Submitting an annual outside audit report.

Preference will be given to providers who are already experienced in effectively serving the poor.

Health Centers operated by the PA Department of Health, will be encouraged to transfer to the Plan's Service Grantees in their areas, direct child health supervision services (well baby) along with any resources freed up by the transfer.

Grants will be competitive, with priorities and the amounts of award based upon 1) documented health status needs (e.g., low birth weight); 2) documented financial hardship (e.g., area unemployment); 3) low participation by other providers in serving the indigent including MA; 4) services proposed; and 5) evidence of local commitment; 6) a feasible long-term finance plan.

Grants will be awarded to applicants in each of the State's regions. Grants would be for a maximum of three years with annual performance reviews and decisions about continuation of funding. After three years, competition will be reopened. There is an expectation that as insurance expands in the state, the need for direct service subsidies will contract.

3. Assistance for Communities without Services Infrastructure in Place

While the strong emphasis of the Community Health Services Program will be on direct service delivery, a few communities will not be in a position to immediately apply for the service grants and may require assistance. There will be two types of limited and targeted assistance available to these communities:

- Providers who fall short in meeting specific criteria for service grants could apply for a small grant to coordinate the linkages among other health care providers. For example, a community might apply for funds to support a liaison between medical providers and social services.
- Communities that need assistance determining their needs and developing a cogent service delivery strategy could apply for small ($20,000-25,000) one-year only grants for help in planning their service delivery applications.

4. Role of the Lead State Agency

The lead state agency will be responsible for disseminating information, soliciting grant applications, setting specific criteria for grant priorities, objectively reviewing grant proposals, coordinating the efforts of any advisors providing technical assistance to local communities, and monitoring grantee performance in the Community Health Services Program. This effort will require the employment of four additional full-time equivalent professionals.

B. Expansion of Physician Supply: Health Professions Loan Forgiveness Program

In a few areas of the state the problem is one of absolute lack of health professionals. For example, Bedford, Cameron, Fayette, and Potter counties currently do not have enough physicians; some counties lack other health professionals such as physical therapists, which is a particular problem in rural areas with a high concentration of elderly. For some of these areas, the current efforts to recruit health professionals coupled with the increasing supply of physicians will be successful, but for other areas it will be difficult to attract health professionals without assistance.

A small health professions loan forgiveness program would provide a supply of providers for the areas that would not otherwise attract providers. Under this program, individuals who are near or at completion of health professions education programs would agree to have the state repay governmental or commercial loans (up to $20,000 annually) obtained for meeting educational costs in return for each year of service they agree to provide in an undeserved area. Priority for placement of health professionals would be given to those provider organizations which receive a Community Health Services grant. Loan repayment programs have two major advantages: 1) they allow the state to quickly place health professionals in underserved areas and 2) they allow the state to take advantage of recent federal legislation establishing a state demonstration program whereby the federal government would pay up to 75 percent of the cost of a state loan repayment program.

C. Ensuring Access to Hospital Care: Uniform Standards for Assessing Eligibility for Charity Care

The Community Health Services program can only be fully successful if patients also have adequate access to inpatient care. For the most part, our study found that the uninsured are able to obtain needed hospital care. However, in some communities some of the uninsured are reportedly deterred from obtaining inpatient care for non-life-threatening conditions by hospital deposit requirements, long waiting lists, and other barriers. Concern was also voiced that hospitals were sometimes not recognizing the potential for MA reimbursement for the uninsured who could qualify for the program once they incur hospital expenses.

Uniform Hospital Standards

To address these problems, and to reinforce the continuing role of hospitals in providing charity care under the new insurance system, we propose that hospitals be required to use uniform standards for assessing patient eligibility for charity care. These standards need to be consistent with the definition of charity care to be adopted by the Council under its data collection requirements.

The uniform standards will be applied first only to inpatient care. Outpatient care will be further studied and a recommendation for including or excluding outpatient care in the definition of charity care will be submitted after the feasibility study is completed no later than October 15, 1988.

We propose that the exact criteria to be used for standardized eligibility be established by a representative working committee of the Council. Using our proposed definition of charity care as a guide, we recommend that all persons in the following categories should be able to obtain inpatient and outpatient hospital charity care (whether or not their conditions were life-threatening or not):[1]

- **Uninsured persons with reported incomes less than 150 percent of poverty, or about $17,475 for a family of four.** A fixed sliding fee scale with a maximum out-of-pocket amount could be used to require at least some payment from these patients, but we urge that no payment be required of persons below the poverty level.

- Hospitals will be required to collect through normal procedures any patient sliding fee scale contributions.

- **Insured persons with incomes less than 150 percent of poverty who have unpaid copayments or deductibles.** Because cost sharing can be substantial for this population, particularly when compared to their low income, this group is included. Also included here are Medical Assistance patients who receive services that are excluded from coverage. Any sliding fee scale applied to the uninsured population would also apply to this group.

- **Hospitals will be required to pursue sliding fee scale amounts** with normal procedures prior to classifying unpaid co-payment or deductibles as charity care.

- **Persons above 150 percent of poverty who have incurred an unpaid personal liability greater than 10 percent of family income.** This allows for charity care to non-poor persons who incur "catastrophic expenses." **Hospitals will be required to assist persons with eligibility for MA** spenddown and collect through normal procedures any unpaid personal liability before it can be classified as charity care.

- **All other persons who will potentially qualify for MA** once an initial calculation of "spenddown" is made based on expected hospital costs. As described under our MA initiative, we are proposing that MA eligibility workers be placed in hospitals (and financed by hospitals) to assist with this process. We propose that any prospective patient who is likely to become eligible for MA through spenddown be treated as a charity case until the spenddown is triggered. Again, any sliding fee scale that applies to the above groups would be applied to this group as well. Thus these patients would be expected to pay at least some of their bills.

These standards would serve as minimums for hospital compliance. Hospitals would be free, of course, to set higher eligibility standards and to thereby allow for more charity care.

These standards should be further refined, implemented, and monitored by the Council or some other designated body. Provisions should be included in the standards that will preclude hospitals from requiring cash deposits, burdensome eligibility procedures, or other potential deterrents to care.

While the standards may appear to result in higher charity burdens for some hospitals, it should be remembered that the indigent care plan includes significant expansion of MA and insurance coverage, both of which will reduce the charity care burden to many facilities.

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[1] See Unsponsored Charity Costs: A Proposed Definition for Hospital Care to the Medically Indigent submitted to the Council by Lewin and Associates on January 17, 1988.

SECTION VIII

EXPENDITURE SUMMARY

The plan is designed for multi year phase-in with no new expenditures required in the 1988-89 budget except those MA items already included in the Governor's proposed budget. The starting dates and multi year phase-in schedule of other insurance/service options will be upon the agreement of the Governor and the General Assembly.

The figures listed are preliminary estimates only, are based on study assumption, and provided subject to:

Final selection of options, (especially in the insurance initiatives), and actuarial/economic impact studies, the results/impact of which will be submitted as formal amendments to the Plan by _____.

	TRUST FUND	OTHER
A. Employer Based Insurance (See Section IV for description)		
Alternative A		
. Vulnerable employer subsidy	$16 million	
. Employer/employee premiums/ Cost sharing: New Insurance		$270 million
. Employer payment in lieu of insurance		$131 million
Alternative B: Not costed: dependent on mix of premium payers.	-----	-----
B. Special Non Group Insurance Program (See Section V, Non-employer Plan)		
. Premium Subsidy	$36 million	
. Individuals premium/cost sharing		$54 million
C. Medical Assistance Potential Expansion/Options (See Section VII for description)	$116.8 million	$102.2 million (federal match)
. Reimbursement floor legislative study (not costed out)	-----	-----
D. Community Service Health Program		
1. Comprehensive Primary Care Grants	$92.00 million	
2. Assistance Grants Contracts		
.Coordinating Grants	1.10 million	
.Planning Grants	0.75 million	
3. Administration	0.42 million	
4. Limited Construction/equipment Purchase	5.00 million	
E. Health Professions Loan Repayment Program	2.30 million	
Total	$270.37 million	$557.2 million

June 30, 1988

TESTIMONY OF GEORGE SILES BEFORE U.S. SENATOR JOHN HEINZ

Good morning. My name is George Siles. I live at 222 Coal Street, Wilkes-Barre, Pennsylvania. I would like to address some remarks to the Committee in favor of passage of S. 1265.

My family is without any health insurance. I cannot afford it, and my employer cannot afford it for me. My employer is not without compassion, but he is financially unable to do anything about my situation. He has particular empathy for me because in the recent past he was unable to afford health insurance for himself.

I have only lately found myself in this dilemma, since for nearly all of my working life I have been provided with health insurance at no cost or little cost to me. While the daily burden of stress caused by the concern for my own health care needs weighs heavily upon me, it is a shadow of what I feel for my wife, my two-year-old daughter and my two-month-old son.

I said earlier that I have only recently found myself in this unhappy situation. I hope it ends soon because there are shocks every week. Sometimes they come at a rate that is almost too much for my wife and me to handle. I suppose that the shocks which come from our inability to pay for absolutely necessary medical services are due in part to my inexperience at being part of what I understand is a substantial part of the population of this country. I can only imagine what it must be like to be permanently mired in the hopelessness of watching one's children damaged for life by inadequate medical attention.

In the past, I took proper health care for granted. It was available to me as freely as the air I breathe. My father was a physician.

My working life began with a career in the profession of Education. As a teacher in public schools in New York, New Jersey and Pennsylvania, I was always in a position of having excellent health care insurance provided at little or no cost. After a few years of public school teaching and with advanced degrees, I became a college professor. I taught at undergraduate and graduate levels of higher education here in Pennsylvania for more than twenty years. Again, health care was a certainty in each situation.

Then, as a result of health problems, I became unable to continue my profession. And, other related reversals destroyed my financial base. At the time I most needed required medical services, I was unable to pay for them. Fortunately, my resources were so depleted that I became eligible for Pennsylvania Medical Assistance. PMA among other things paid for major heart surgery and the pre and post care necessary to make it a successful part of a process of recovery.

Unfortunately, with my health restored to the point that I can work and support my family and remove myself from the various subsistence benefits that are provided at the poverty level in this county, state and nation, I became ineligible for continued health care assistance. My wife and I reviewed the possibilities of living on a very meager budget and decided to gamble that we would all remain healthy.

We had previously investigated all the available health care insurances in an attempt to locate something that we could afford. After allowances for food, clothing and shelter, we painfully discovered that with the remaining money available to us, the best we could do was lessen the risk a bit by budgeting a few dollars a week for medical emergencies and try to save enough for visits to doctors and dentists. We have to forego a great deal of medical attention which I had previously thought was routine--especially for children.

As a former teacher of children and one who prepared others to teach children, it is all very painful to see one's own babies receive insufficient medical care. While our decision has been to work at something which provides a useful service to society, pay taxes, provide our children with a role model of a working parent, it causes a very heavy price to pay. The decision has cost us proper medical attention.

I realize that my situation may be viewed as unusual. I would hope that there are not too many professionals with doctorates from prestigious Pennsylvania universities who are in my position. However, it may be that each individual situation is unusual. I may not be as unusual, except in its particulars, as the common mythology about the poor and working poor in this country would have us believe. My understanding is that the majority of people in my situation, having been brought there by whatever circumstances, are working people.

One of my best clients of the little firm where I am employed helped me move some furniture which someone had donated to my family earlier this month. As we were riding along, and in the course of conversation, I asked him if he provided health insurance to his employees. I knew that he was a small businessman, very competent in his work, and able to employ several skilled craftsmen to assist him with his contracts.

His response was interesting to me and I should think of some value to anyone who is considering the merits of medical support for low income families. The contractor, who is a compassionate man, told me that he was unable to provide health insurance to his employees now, and that made it difficult to retain some workers. This was aside to this problem that frankly I had not previously considered: that the lack of adequate health insurance in this country would have an adverse effect on a businessmman in just this particular way.

That my employer cannot afford health insurance for my family is something I can understand, that I must endure the agonies of seeing my family receive medical care with great gaps in it compared to other children. What I cannot accept is that the richest country in the world is one of only two western oriented nations that does not assist its working, productive citizens with adequate health care.

As one who has worked in the development of children's minds, I have difficulty accepting that we can neglect proper care for their bodies.

One of the constant lessons to me from my father, a physician, was the incontravertable greatness of this country. I believed him as a child and I believe him now. Still, how would he feel the sorrow of his grandchildren not receiving the complete array of health safeguards necessary for development into strong, healthy, productive adults which are available to those who can afford them or who have adequate health insurance.

I have a deeper sense of inadaquacy of the medical care I am presently able to provide for my family. This is my second family. My first family enjoyed all the medical attention they required and perhaps even some of that went beyond absolute requirements for adequate maintenance of health. For me, to do otherwise was unthinkable. I had health insurance.

Now, though I work diligently at my job and expend as much physical and emotional energy to provide for my present family, cirumstances beyond the immediate control or wishes of myself or my employer make it impossible for my children to get that same level of medical attention. It's a comparison I would hope few fathers have to make. My daughter and son are growing up in the same society as their older siblings, except that our medical science has made great progress, and they are not benefitting from even the same level of medical care which I saw provided to their two sisters.

My wife and I are middle-class Americans by every standard and sociological definition I ever studied. We are in the mainstream. We are free of any affliction from alcoholism, drug abuse or atypical behavior. We budget our money prudently and judiciously. We love our children and our country and each other. We simply seek relief from the daily stresses of being unable to provide adequate medical care for each other and our children. Thank you.

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TESTIMONY
ON BEHALF OF THE
BLUE CROSS PLANS OF PENNSYLVANIA
ON
INDIGENT CARE

by

GILBERT D. TOUGH, CAM
PRESIDENT & CHIEF EXECUTIVE OFFICER
BLUE CROSS OF NORTHEASTERN PENNSYLVANIA

JUNE 30, 1988

Good morning, Senator Heinz. I am Gilbert D. Tough, President and Chief Executive Officer of Blue Cross of Northeastern Pennsylvania. My comments this morning are on behalf of the Commonwealth's four Blue Cross Plans.

We appreciate the opportunity to testify before you on the issue of health care for the medically indigent.

Our basic mission as Blue Cross Plans is to offer quality, affordable, and accessible health care to all residents of the Commonwealth.

To carry out this mission:

-- We offer open enrollment and in some Plans continuous open enrollment

-- We do not age rate

- We do not underwrite coverage based on health or economic status
- We insure anyone regardless of risk
- We do not cancel coverage because of extensive use of benefits
- We community rate

That philosophy and practice has been carried through with innovative programs implemented by us to help keep the percentage of medically indigent in Pennsylvania well below the national average (as stated in the preliminary report by Levin & Associates).

Two of these innovative programs are:

- Our own Plan's program for the unemployed, and
- Blue Cross of Western Pennsylvania's "Caring Program for Children."

In general, we believe that there currently exists a variety of alternatives for providing health care to the medically indigent.

We believe that the basic thrust of any effort should be in the context of what we call "marginal improvements in coverage." We believe this approach is the most realistic, the most practical, represents the least traumatic way of dealing with a complex health care system, and best allows for setting priorities. We also believe it will involve the lowest incremental cost.

Within that basic approach, here are some of the considerations we believe are important.

1. Refinements in the medical assistance program should continue. These should include:

   - The simplification of provider administrative responsibilities at the state level.

   - The development of an outreach program to help remove the perception that sometimes stigmatizes these programs as only for the poor. Those who are eligible should be encouraged to recognize that it is a part of the social safety net exactly as unemployment compensation is a part of the safety net.

   - Outpatient care must be further encouraged through an increase in the allowances for providers, and also through programs to encourage, financially and otherwise, primary physician management of a patient's health care. Pennsylvania's Blue Cross Plans rely on pre-certification, second surgical opinions, utilization review, and managed care to accomplish these goals. These approaches should, over time, prove to be cost effective enhancements to the program and are all steps to be taken.

2. While the Blue Cross Plans are willing to consider additional programs that would assist those who are

uninsured or underinsured, it must be recognized that any new subsidized programs we may undertake must draw their subsidy dollars from the same pool that our current subsidized programs rely on. Statewide, we insure nearly 7 million people, of whom almost 375,000 are non-group hospitalization subscribers under 65. Last year we subsidized coverage for our non-group hospitalization and major medical subscribers by over $79.3 million, contributed $49.9 million to assist hospitals in providing charity care, and also subsidized Medicare supplement subscribers. These monies ultimately come from our employer customers. We cannot increase the subsidy levels without jeopardizing our competitive position.

3. Nevertheless, we believe there are opportunities to use the private sector. For instance, subsidizing persons currently ineligible for medical assistance so that they could choose either to buy in to medical assistance or to buy in to available private insurance programs. We particularly believe in the desirability of preserving some element of consumer choice for all segments of the population.

4. At the same time, it will be important in developing any program to distinguish clearly between those persons who cannot obtain a health care program and those who have chosen not to obtain such a program. For example, it appears that there are approximately 1 million persons in Pennsylvania estimated to be uninsured. But of those, approximately 200,000 have incomes in excess of $22,400 or 200% of the federal poverty level. These persons may have the resources to protect themselves but have not

done so. It seems to us, therefore, that the dimensions of the problem are really best measured by people who not only lack insurance, but also lack the resources to purchase it.

5. We do believe, however, that the Commonwealth may have a role to play in connection with private insurance programs. We believe in a competitive insurance marketplace. That implies that regulation should not stifle the availability of a variety of products and services. But we do have concerns over the very limited programs that are sold by some insurers. Such programs may contribute to the problem of underinsurance when persons who could purchase more comprehensive insurance benefits seek to save money by purchasing coverage that pays only a small percentage of health care expenses. We believe, therefore, that an option to require a set of minimum benefits in health insurance plans deserves more consideration.

6. Finally, we note that the preliminary work of Levin & Associates in studying the indigent care issue in Pennsylvania has essentially indicated that the biggest problems of access to health care are in the primary care area. Moreover, not only is inpatient care available, but there seems to be no current crisis in the funding of inpatient care. Those observations confirm what our own analyses have suggested over the past several years. It is important to recognize that, fortunately for the Commonwealth, most Pennsylvania hospitals are non-profit community hospitals with a tradition of serving the entire community and, we believe, an obligation to

> continue doing so. We recognize the difficult choices many hospitals face today, in a time when competition, in various forms, has become far more important in the health care industry. But ultimately, it is equally important to recognize that hospitals exist not merely to survive the competitive struggle, but also to serve. We hope the continuing fulfillment of that obligation will be one of the key elements in any solution to the problems of the medically indigent.

We believe any program designed to address the indigent care issue must be done in a building block fashion because of the complexity of the issue.

And, because of the mission and the activities of the Pennsylvania Blue Cross Plans our continued competitive viability must be ensured.

We appreciate your time, and the opportunity to testify for the record on this complex issue. Thank you.

0929M

June 29, 1988

To The Honorable Senator John Heinz

My name is Charles Christian Wolferth, M.D. I am Professor of Surgery at Hahnemann University School of Medicine in Philadelphia, Pennsylvania. Since 1977, I have been a member of the American College of Surgeon's Committee on Trauma. The College of Surgeons has had over 5 decades of interest in improving the care of the injured. Members of the Committee on Trauma helped the National Research Council issue a White Paper labeling trauma "the neglected disease of modern society" over 22 years ago. A 12 year follow up study of emergency medical services revealed that progress in implementing regional trauma systems was disappointingly slow. Subsequent trauma death studies have documented that 1/3 of trauma deaths in non-designated hospitals were preventable. Since 1976, the American College of Surgeons developed the Optimal Resource Document which developed strict criteria for establishment of trauma centers and of trauma systems. This document has been periodically updated, the most recent Optimal Trauma Resource Document was published in the Bulletin of the American College of Surgeons in October, 1986.

Last week Drs. John G. West, Donald D. Trunkey and I published in the June 24, 1988 issue of the Journal of the American Medical Association, our review of the 8 essential components of regional trauma systems based on criteria set forth by the American College of Surgeons. Only 2 states were found to have all components of state wide trauma coverage. Nineteen states and the District of Columbia lacked one or more components of a regional trauma system. Perhaps the most important finding in our article was the finding that the remaining 29 states had yet to initiate a process of trauma center designation.

Some regions and cities, if not states, have been significantly ahead of the rest of the country in the designation of effective trauma systems. Approximately one year ago, I completed a study which identified approximately 286 trauma centers throughout the country with a very uneven geographic distribution. Approximately 140 of these centers have undergone some form of outside peer review, the rest are self designated. Over half the population of the United States is not served by any formally recognized trauma designation process or system.

On the basis of having served as a trauma center site reviewer in over 100 hospitals throughout the country during the past 7 years, I am aware of how delicately balanced is the process where good trauma care does exist. In fact, effective trauma care is beginning to deteriorate where it previously existed in some of the longer established trauma areas and is sure to happen in the other few more recently developed areas as well.

Two excellent examples of the precariousness of trauma care are the fact that 7 of 17 designated trauma centers in the Los Angeles area and 4 of the 5 trauma centers in the Miami area have closed during the past year. The overwhelmingly single most important factor in the closure of these trauma centers is simply the inability of these hospitals to provide for uncompensated indigent care. Virtually all hospitals in the United States today can and do provide for a reasonable amount of uncompensated indigent care. When a trauma center receives, by its nature, significantly higher percentage of what would otherwise be its fair share of uncompensated care, the choice that many trauma center hospitals must make is either to drop out of the system or go bankrupt. Many are dropping out of the trauma system.

Trauma care by its nature is extraordinarily expensive but if lives are to be saved, institutions willing to make the trauma center level provision of care must be compensated fairly for indigent and uncompensated care. Nationally, it costs approximately $13,000 per average trauma admission for hospital costs alone. A hospital that receives 500 uncompensated indigent trauma patients per year can expect that non-reimbursed costs for these patients alone will total $6,500,000 per annum, a figure that most hospitals cannot bear.

Another excellent example of this short fall is a Level I trauma center in the District of Columbia which provided over 6 million dollars of trauma care for the citizens of the District of Columbia and was reimbursed 9.4% of these costs during fiscal 1987. Essentially this institution provided over 5.5 million dollars of free trauma care just to the citizens of Washington D.C. not to mention the 2 million dollars of uncompensated care given to the citizens of Maryland and over 1 million dollars to the citizens of Virginia. There are few hospitals in the country that can afford to do this over any period of time without serious disruption to vital medical services or its own survival.

Another area of major concern to those of us who are involved in the day to day provision of trauma care services is the virtual impossibility of obtaining long term, vitally needed, rehabilitative services for the trauma victim who does not have comprehensive major medical insurance. These vitally needed services are not inexpensive and are a major factor in the short fall of trauma care services.

It is my firm conviction that enlightened, comprehensive, federal legislation and funded care for the trauma victims not otherwise covered must be mandated and is the only realistic solution. Trauma is the leading killer of the young and through the fourth decade of life. Because it is a killer of the young and otherwise healthy person, trauma accounts for more years lost of productive life than cancer and heart disease combined and remains today the neglected disease of modern society.

I appreciate the privilege of presenting my testimony to you this morning.

Concepts in Emergency and Critical Care

Trauma Systems

Current Status—Future Challenges

John G. West, MD; Michael J. Williams, MPA; Donald D. Trunkey, MD; Charles C. Wolferth, Jr, MD

The national status of regional trauma system development was evaluated by a survey sent to all state emergency medical services directors and state chairpersons of the American College of Surgeons Committee on Trauma. Eight essential components of a regional trauma system based on criteria set forth by the American College of Surgeons were listed. Only two states were found to have all components and statewide coverage. Nineteen states and the District of Columbia lacked one or more components of a regional trauma system. The remaining 29 states had yet to initiate the process of trauma center designation. In response to these shortcomings, an attempt was made to define the barriers to trauma system implementation and a step-by-step process was outlined for the development, management, and analysis of a comprehensive system of trauma care.

(*JAMA* 1988;259:3597-3600)

TWENTY-TWO years ago, the National Research Council issued a white paper labeling trauma "the neglected disease of modern society."[1] A 12-year follow-up study[2] of emergency medical services (EMS) at midpassage revealed that progress in implementing regional trauma systems had been disappointingly slow. Subsequent trauma death studies[3,4] demonstrated that one third of trauma deaths in nondesignated hospitals were preventable. The American College of Surgeons developed criteria for the designation of trauma centers and the establishment of trauma systems.[1] Regions that have adopted these criteria have experienced a dramatic reduction in the percentage of preventable deaths.[4-6] Despite the documented effectiveness of regional trauma systems, many regions have yet to implement them. This article attempts to define the current national status of statewide trauma systems and provides a strategy for the development, management, and analysis of such a system.

METHODS

All state EMS directors, or health departments having responsibility over emergency and trauma planning, were contacted during a telephone survey in February 1987 and were asked the following eight questions: (1) Does your state have the legal authority to designate trauma centers? (2) Does your state have a formal process for designating trauma centers? (3) Does your state use the American College of Surgeons' standards for trauma centers (Table 1)? (4) Do you use out-of-area survey teams for trauma center designation? (5) Is the number of trauma centers based on patient volume or the population of the area? (6) Are triage criteria in writing and do they form the basis for bypassing nondesignated hospitals and sending patients to trauma centers? (7) Are there ongoing monitoring systems for trauma centers? (8) What percentage of your state is covered by trauma centers? These questions were based on specific recommendations set forth by the American College of Surgeons and were selected because they were judged by the authors to represent the essential components of a regional trauma system.

A written summary of each state's status was recorded and returned to the state director for corrections in March 1987. A similar survey was sent to all state chairpersons of the American College of Surgeons Committee on Trauma. Discrepancies between the responses from the state chairpersons and from the EMS directors were resolved through follow-up telephone interviews.

RESULTS

All fifty states, plus the District of Columbia, responded. Only two states (Maryland and Virginia) were identified as having all eight essential components of a regional trauma system. Nineteen states and the District of Columbia either had incomplete statewide coverage or lacked essential components (Table 2). The EMS directors in these states were unable to accurately estimate the percentage of the state population or geographic area covered by the designated trauma centers. Overdesignation was a common problem. For example, in Missouri there were 62 designated trauma centers, or one per 80 000 residents. In Washington, DC, there were five level I trauma centers for a population of 750 000, or one per 150 000 population. The EMS directors in these states also judged triage and quality assurance programs to be inadequate. For example, in the city of New York it was estimated that only one third of critical trauma patients were triaged to the eight designated level I trauma centers. Twenty-nine states had yet to initiate the process of trauma center designation (Table 3).

COMMENT

This survey of the current national status of state trauma systems reveals widespread fundamental problems. Only two states had all eight essential components of a regional trauma system. Twenty-nine states had yet to initiate the process of trauma center de-

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From the Department of Surgery, St Joseph Hospital, [illegible] (Dr West); EMS Systems Design, Irvine [illegible] (Mr Williams); Department of Surgery, Oregon [illegible] Sciences University, Portland (Dr Trunkey); and Department of Surgery, Hahnemann University Hospital, [illegible] (Dr Wolferth).

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Advisory Panel: Richard O Cummins, MD, Seattle; Joseph E Parrillo Jr, MD, Bethesda, Md; and Donald D Trunkey, MD, Portland, Ore.

Table 1.—Summary of American College of Surgeons Standards for Trauma Centers*

Level I
In-house trauma surgeon
In-house anesthesiology
Optimal trauma patient care
Physical plant/staffing/equipment
Trauma quality assurance process
Trauma training programs
600-1000 trauma patients/y
Trauma public education
Teaching program
Research

Level II
In-house trauma surgeon†
In-house anesthesiology‡
Optimal trauma patient care
Physical plant/staffing/equipment
Trauma quality assurance process
Trauma training programs
350-600 trauma patients/y
Trauma public education

*From reference 9.
†Present on patient arrival.
‡Present on patient arrival or shortly thereafter.

signation. Fundamental problems of system design including overdesignation, lack of triage criteria, and inadequate monitoring existed in the remaining states.

The survey had its limitations. State EMS directors and state chairpersons of the Committee on Trauma may have lacked information on regional trauma system development as well as quality of care. The survey did not address the issue of adequacy of trauma care in nondesignated systems nor did it evaluate the effects on quality of care when a region lacked one of the eight components. Other important components of a comprehensive regional trauma system—such as prehospital care and rehabilitation—were not evaluated. Also, states with all eight components could have fundamental problems in delivering appropriate care to the individual patient. This survey was designed to evaluate state compliance with trauma guidelines from the American College of Surgeons. Despite its limitations, it is clear that in the 22 years since the white paper progress in implementing regional trauma systems has been slow.

This slow progress is not due to a lack of direction. The American College of Surgeons' trauma resource document and its appendixes[9] provide a detailed description of the component parts of a comprehensive system of care. What is missing is a practical strategy for the implementation and management of such a system. The following step-by-step process attempts to meet this need and also provides further clarification of the eight essential elements of a regional trauma system.

Step 1—Basic Data

The first step in developing a regional trauma system is to define the magnitude of the local trauma problem. Autopsy studies have been of value in this regard, but in the absence of prehospital and hospital data this method underestimates the magnitude of the problem.[10,11] When possible, regional trauma reviews should include all available clinical records.[12,13] The added clinical information allows for the measurement of the timing of therapy, adequacy of resuscitation, judgment, and other treatment parameters. It also proves to be of greater value in convincing local authorities of the need for change and provides a sound database for future comparisons. Regions lacking mandatory autopsies can perform preventable-death studies by using hospital and prehospital records.[14] Out-of-region experts should be recruited to add credibility and objectivity to the process of data gathering and interpretation.

Step 2—Develop a Comprehensive Regional Plan

A regional plan should be developed that deals with care of the trauma victim from the field to complete rehabilitation and should be based on standards set forth by the American College of Surgeons' (Table 1). Local surgeons should provide strong leadership in plan development. The plan must take into account such local issues as medical and financial resources, population distribution, and funding alternatives. The plan, at a minimum, should address the following ten issues:

1. Prehospital care: The key ingredient of optimal prehospital care is medical control.[15] The plan should also identify such issues as field treatment protocols, communications, and training (Richard H. Cales, MD, Glen W. Mitchell, MD, Gary Tamkin, NREMT, et al, unpublished data, April 19[illegible] through May 1985).[16,17]

2. Air transport: Helicopter and fixed-wing air transport should be integrated into the regional trauma plan so its added costs can be justified by defined medical benefits (Lenworth M. Jacobs, MD, MPH, Barbara Bennett, RN, MPH, unpublished data, June 19[illegible] through June 1987).[18] Protocols should establish who calls the helicopter and when.

Table 2.—States Lacking Complete Coverage by Designated Trauma Centers or Lacking One or More of the Essential Components of a Regional Trauma System

State	Formal Legal Authority	Formal Designation System	Use of American College of Surgeons' Standards	Use of Outside Survey Team
California	X	X	X*	X
Delaware	X	X	X	X
District of Columbia	X	X	X	X
Florida	X	X†	X	X
Georgia	X	X	X*	X
Idaho	X‡	X	X*	X
Illinois	X	X†	X	X
Mississippi	X	X	X	X
Missouri	X‡	X	X*	X
New Hampshire	X	X	X	X
New Jersey	X	X	X	X
New Mexico	X	X	X*	X
New York	X	X	X	X
North Carolina	X§	X	X*	X
Oregon	X	X†	X	X
Pennsylvania	X	X	X	X
Rhode Island	X	X	X	X
South Carolina	X	X	X*	X
Utah	X	X	X	X
West Virginia	X	X	X	X

*Modified.
†Pending.
‡Planned or voluntary.
§Categorization.

Table 3.—States With No Formal Trauma Center Designation

Alabama
Alaska
Arizona
Arkansas
Colorado
Connecticut
Hawaii
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Massachusetts
Michigan
Minnesota
Montana
Nebraska
Nevada*
North Dakota
Ohio
Oklahoma
South Dakota
Tennessee
Texas
Vermont
Washington
Wisconsin
Wyoming

*Legislation recently approved and trauma plan under development.

3. Triage: A region must define a major trauma victim. Formal triage criteria must be developed that are sufficiently sensitive to identify the vast majority of trauma victims at risk for life-threatening injuries.[illegible]

4. Trauma center designation: The criteria for trauma center designation and the number of centers designated should be based on standards set forth by the American College of Surgeons[illegible] (Table 1).

5. Quality assurance: Quality assurance evaluation must be performed at the following levels of care:

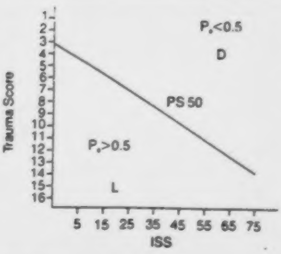
- Prehospital: Emphasis should be placed on prehospital deaths occurring after the arrival of the first responders. Other issues should be evaluated, such as prolonged field times, field treatment protocols, and adequacy of the medical record.
- Hospital: All hospital deaths and major complications should be routinely reviewed. Trauma registries should be implemented and audit filters should be used to pinpoint deficiencies. The Trauma Score/Injury Severity Score or a similar method should be used to compare results of care with other trauma centers as well as with the national norm[illegible] (Figure). When specific problems are identified, more detailed audits may be necessary. The system must be sufficiently flexible so that once problems are identified, appropriate changes can be made.
- Regional reviews: Regional reviews should focus on the issues of regional scope, such as overtriage and undertriage and the development of regional treatment protocols.
- Review by outside experts: Following designation, regional reviews by out-of-area experts could be requested when a region falls below the national standards (as measured by the Trauma Score/Injury Severity Score or equivalent methodology) or when there are irresolvable local problems. Inclusion of out-of-area reviews adds credibility and objectivity to the review process.

6. Specialty care problems: Protocols or transfer agreements should be developed for specific problems such as pediatric care, burns, and spinal cord injuries.[illegible]

7. Research: Level I trauma centers should be involved in basic trauma research and level II hospitals should at least be involved in the evaluation of epidemiologic data and individual case studies.

8. Rehabilitation: Comprehensive rehabilitation services must be available for all trauma victims starting as early in the treatment cycle as possible.

9. Prevention and public education: All trauma centers should be involved in both prevention as well as public education activities.



Trauma Score/Injury Severity Score method of comparing patients' outcomes. Trauma Score/Injury Severity Score methodology gives expected patient survival based on regression equation utilizing age of victim, severity of injury (measured by Injury Severity Score [ISS]), and physiological status of patient. Based on outcome norms calculated from trauma patient sample of over 24 000 patients, graph may be plotted of probability of survival (P_s) vs actual patient outcome. L indicates lived; D, died; and PS 50, percentage of survival.

10. Disaster planning: There should be a linkage between the regional trauma plan and the regional disaster plan. Trauma center personnel should play an integral role in disaster planning and management.[illegible]

Step 3—Identify the Barriers to Change

Before attempting to implement the trauma plan, it would be useful to identify the potential barriers to change and outline strategies to overcome them. The major barriers to change are economic. Hospital administrators are concerned that if competing hospitals receive trauma center designation, they will attract an increased volume of nontrauma patients. A recent study[illegible] did not support this concept of a "halo effect."

Hospital administrators have concerns regarding the adverse economic impact associated with trauma center designation, even though one inner-city teaching hospital has reported a positive financial impact following designation.[illegible] Trauma centers have dropped their designation in Miami and Los Angeles. Ostensibly, this was a result of the adverse financial impacts from a high percentage of indigents as well as concerns about rising malpractice premiums. However, other factors, such as an inappropriate distribution of indigents among various receiving centers, a lack of commitment, and a lack of development of important support components of a trauma system, may also have played a significant role.[illegible]

Table 4.—Trauma System Tasks of a Lead Emergency Medical Services Agency

Facilitate the development of a regional plan
Perform initial temporary trauma center designation
Conduct data collection and assimulation
    Prehospital and base station records
    Trauma registry forms
    Regional trauma data reviews
Provide staff support to regional trauma advisory committee and audit committee
Coordinate out-of-region expert reviews
Coordinate prehospital care, including training, transportation, and communications
Redesignate trauma centers or perform disciplinary role (ie, warning, probation, or dedesignation)
Development and monitoring of regional protocols (ie, interhospital transfer, triage, system overload, etc)
Monitor air transport system
Coordinate with adjacent regional and state programs

The costs of operating a community hospital trauma center are known.[illegible] However, there has been concern raised on the revenue side of trauma centers, particularly related to diagnosis related groups (DRGs), which are reported to severely underestimate reimbursement of trauma care.[illegible] Fortunately, DRG patients usually make up a small percentage of the total trauma patient population. However, to date there are insufficient data to accurately predict the economic consequence of trauma center designation in regions with large indigent populations. Such regions might choose to identify alternative funding sources prior to trauma center designation.

Physicians face similar economic challenges. In addition to the indigent and DRG problems, the trauma victim often requires a greater time commitment than do elective cases with similar rates of reimbursement. The trauma victim frequently arrives at inconvenient hours, is often unappreciative of the care given, and is perceived to pose an increased medicolegal risk. To surmount these problems, a select few physicians with a strong commitment to high-quality trauma care and willing to accept the fundamental limitations should constitute the nucleus of the trauma treatment team. If there is insufficient commitment by local physicians, out-of-region physicians should be recruited.

While there are other barriers—such as lack of resources, problems with elected officials, and lack of public awareness—problems with hospital administrators and physicians are usually the most formidable.

Step 4—Develop a Management Structure

The lead agency must be given formal, legal authority for trauma center designation as well as the ability to perform the other tasks listed in Table 4. In most cases, the lead agency will be the Office of Emergency Medical Services or the Department of Health. Colorado and Pennsylvania have developed an independent foundation for trauma center designation, but the value of such an alternative approach has yet to be defined. The lead agency should work in concert with both a regional trauma advisory committee that sets policies and procedures and a medical audit committee that evaluates the quality of regional trauma care.[37]

Step 5—How to Implement the Plan

Once the plan has been developed, all regional hospitals should be encouraged to participate. Hospitals seeking designation may request a verification of compliance with criteria through a visit from representatives of the American College of Surgeons. The college will perform verification with permission from the local designating agency.[38] The local agency may choose to combine verification with a comprehensive trauma system review that includes additional survey team members such as an emergency physician, hospital administrator, nurse, etc. This expanded review team would assist the designating agency in implementing all aspects of the regional trauma plan. Following the review, the lead agency would temporarily designate a limited number of trauma centers. The number of hospitals designated would be based on survey performance as well as regional resources and population distribution.

In the event that a region failed to implement a regional trauma system, the temptation of watering down the criteria to facilitate hospital participation should be avoided. Under these circumstances, the process of data gathering should continue. Regional planners could also look to outside sources for assistance, such as state EMS directors and committee chairpersons from the American College of Surgeons. Further support could come from enabling legislation. Such legislation must (1) define the authority to implement a regional trauma plan; (2) define the essential components of its trauma plan; (3) define the management structure; (4) define the elements of a comprehensive quality assurance evaluation; (5) provide financial resources to implement and maintain the regional plan; and (6) provide the authority to coordinate the plan with surrounding regions. Also, the medical and hospital communities must be appraised of the increased medicolegal exposure that occurs when trauma victims are not cared for within an organized system of care.

Finally, the public must be made aware of the consequences of not having a regional trauma system. To date, the public has been remarkably silent on the trauma issue, but its silence should not be interpreted as indifference. The public clearly expects high-quality health care and has allowed the medical community great leeway in developing appropriate systems. Failure to implement a national network of comprehensive regional trauma systems could result in a backlash of public opinion that would open the door to outside control and regulation. We must aggressively pursue a solution to the trauma dilemma to avoid such intervention and, more importantly, to ensure the highest quality of care for our communities.

The authors gratefully acknowledge Marty Karpiel, MPA, for his assistance in conducting the survey of the state agencies noted in this study. The Figure is reproduced with permission from reference 9.

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COMMUNICATIONS

American
Academy of
Pediatrics

The Pennsylvania Chapter of the American Academy of Pediatrics appreciates the opportunity to present written testimony to the Senate Finance Subcommittee on Health on medical indigency in Pennsylvania's children. We have also provided input to help the PA Health Care Cost Containment Council develop a comprehensive plan to address the problems of the uninsured.

On January 26, 1988, the PA Health Care Cost Containment Council (HCCCC) issued the 'draft' Lewin Report, Analysis and Recommendations on Health Care for the Medically Indigent as mandated by PA Act 89. The HCCCC set up a series of statewide public hearings to take testimony on the proposal. To attain its goal that 'every person in the Commonwealth receives timely and appropriate health care', the report outlined three broad alternative approaches to assure universal access for all Pennsylvanians:

I. Making marginal changes in existing insurance programs, including medicaid, by building upon the foundation of the current public/private insurance system;

II. Expanding insurance coverage to new groups through new insurance initiatives;

III. Seeking universal insurance coverage through new public/private initiatives.

PA AAP leadership welcomed the opportunity to advocacate for compensated, comprehensive care for all PA children, and organized a statewide response to the HCCCC report.

Declaring that "children are disporportionately represented among the medically indigent in PA and should not be denied access to the health care system because of financial barriers", Narberth pediatrician Jerold Aronson, M.D. was the opening speaker at the HCCCC in Philadelphia on February 16, 1988. Dr. Aronson called for the creation of **"a comprehensive plan to assure access which builds upon the stengths of the existing health care financing system, promotes efficient use of non-institutional ambulatory care, assures quality, contains costs and is affordable by business and government in the Commonwealth." PA AAP challenged the HCCCC to develop a socially just public/private partnership to assure access such that "every employed individual has the opportunity to provide for the basic health and welfare of themselves, and their dependents through their work, with government having the residual responsibility of providing a 'safety net' of financing and services for those incapable of providing for themselves"**. Dr. Aronson also expressed concern about the increasing number of PA companies that are self-insuring and thus exempting themselves from state insurance regulations under ERISA, and potential participation in the proposed 'pay or play' plan for PA.

At the HCCCC hearings in Scranton, PA, on March 4, 1988 three PA pediatricians, Dennis Dawgert, M.D.(Scranton), Pat Rossi, M.D. (Wilkes Barre), and Alan Kohrt, M.D. (Tafton) presented testimony on rural medical indigency, and preventive health care for children. Dr. Kohrt reminded the HCCCC that **"children whose parents have health care benefits which include preventive well child care are few in number. Most of the cost is out-of-pocket, forcing even middle class parents with health insurance who** cannot afford the increasing cost of immunizations to either attend state health department immunization clinics or omit one or more of their scheduled health maintenance visits." As a physician with 12 years of service in a state funded well child clinic, Dr. Kohrt shared his frustration about the inability of the clinic to provide an appropriate level of well child preventive care and anticipatory guidance due to the limited physician time with patients, decreasing numbers of public health nurses, and limited visit schedules. He presented data from the Communicable Disease Center showing a decrease in the number of fully immunized 2 year olds during the 5 year period 1980-1985 as well as vaccine cost-benefit ratio data. PA AAP recommended that PA provide free vaccine for all PA children to be administered at the child's regular site of comprehensive preventive health care.

Dr. Dawgert, discussed the comprehensiveness and affordability of preventive health care in accordance with AAP Guidelines for Preventive Health Care and reminded HCCCC members that the AAP recommendations recommendations for Preventive Health Care were developed for well children receiving competent parenting, not generally the case with medically indigent children. "The total cost to provide all child health supervision services required from birth to age 20 years is less than the cost of one day in a children's hospital", said Dr. Dawgert. Utilizing data from the PA Blue Shield 'Pediatric Preventive Health Maintenance Benefit experience which covers state AFSCME members, although not meeting AAP recommendations, Dr. Dawgert stated our belief that "it is possible to insure all PA children for comprehensive, continuous, primary care without breaking the bank."

Dr. Patricia Rossi shared her 15+ years of experience with the Rural Health Corporation of NE PA and her extensive first hand knowledge of the access problems for rural medically indigent families caused by decreases in clinic funding, limited physician availability, the time and out of pocket costs associated with visits to the physicians, and a complete or partial lack of health insurance. "The problem is basically a lack of money!", she said. Physicians who might be interested in rural health "can't earn a living, and close their office despite the availablility of patients. Out of practicality they have to settle where they can get paid for their services. There is no doubt in my mind that physicians will be available for service if they can get a 'just' payment for their services", Dr. Rossi said.

Jerry Wolfson, M.D. (Pittsburgh), past President of the Pittsburgh Pediatric Society with 17 years of experience in running two store front clnics for low income children and families in addition to his private practice testified in Pittsburgh February 26, 1988. He expressed concern that "children in families whose income is not low enough for medicaid but unable to afford the rising cost of medical care get only care that is absolutely needed - acute emergency care for illness that has been allowed to go on too long before seeking help; immunizations not spread out for maximum benefit but often given in a crash course in order to be able to get the child into school." "As a pediatrician it is my feeling that the most important service that I can deliver to families, apart from obvious sick care needs and immunizations is what I call child rearing practice. It is my pediatric expertise that helps families raise kids so that they can realize the goals for their children, independence, good health and success. I want to take care of the who child and meet all of his needs. The way the system operates today conspires against this", said Dr. Wolfson.

PA AAP has vigorously supported PA expansion of Medicaid to the maximum allowed by federal law. Barbara Harley, M.D.(Johnstown) testified, "the use of a single primary care provider to guide each child's ongoing care, a medical home, is good economic and health sense." She urged complete adoption of SOBRA 86 and early implementation of SOBRA 87, periodic increases in medicaid office fees and an increase in the EPSDT fee schedule proportionate to the medicaid office visit fee schedule, and adoption of the AAP periodicity of visit schedule for the PA EPSDT program. "Regular fee schedule changes make a program like EPSDT attractive to qualified providers and will improve the access of indigent children to quality pediatric care", said Dr. Harley.

Philadelphia neonatologist Frank Bowen, M.D. travelled to Williamsport, PA to present his testimony to HCCC. Dr. Bowen, PA AAP participant in the Healthy Mothers/Health Babies Coalition highlighted the special problems associated with preventable teen pregnancy and low birth weight babies. The establishment of "presumptive medicaid eligibility for pregnant teens under Sobra 86 is only a start: solving the social problems which foster teen pregnancies will require broader, interdisciplinary, efforts than those of the health care system alone."

PA AAP supports adoption of a comprehensive Plan for the Medically Indigent which:

1) Expands medicaid eligibility and benefits to the maximum permitted under federal law, while modifying fee schedules, and administrative practices to encourage provider participation,

2) Creates a broadly funded Indigent Care Trust Fund to manage, administer, and disburse the funds for medical indigent care initiatives other than medicaid,

3) Creates tax code incentives for new group and individual insurance products to be purchased for employed individuals and

their dependents by employers which contain minimum benefits emphasizing primary and preventive health care and immunizations for children to age 21 in accordance with AAP guidelines,

4) Expands incentives for the development of community health centers and physician recruitment in medically underserved areas of PA, and

5) Funds free vaccine for all PA children administered in physicians offices accompanied by non-negligent vaccine injury compensation legislation to maximize the immunization of PA children and the savings on vaccine costs available through the vaccine compensation law.

Unfortunately, during the final meetings before the HCCCC deadline of July 1, 1988 for the submission of its Medically Indigent Plan to the PA legislature, the carefully nurtured coalition of business, labor, government, and providers fell apart. The comprehensive proposal became a series of recommendations for legislative consideration. PA AAP believes that comprehensive action to assure access by medically indigent pregnant women and children through age 21 to quality health care will require:

* federal review and reform of ERISA to 'level the playing field' and require full participation in a 'share the care' by all insurors and employers,

* continued federal expansion of eligibility and benefits for pregnant woment and children under medicaid,

* political leadership from PA Governor Robert Casey and PA legislators.

PA pediatricians stand ready to vigorously support comprehensive legislative efforts, and to provide the health care required by the children to enable them to become competitive, productive, healthy contributors to our society.

Commentary/Caring for the Poor

Medical Care for the Poor: No Magic Bullets

LESS than a quarter of a century ago, at the time of the Great Society programs of President Lyndon Johnson, many believed that with the passage of Medicare and Medicaid a single standard of superior medical care for all Americans was at hand. Governmentally funded entitlement for the elderly and the poor, the two major groups that lacked private health insurance, promised that the problem of access would soon be history. Clearly, that expectation has not been fulfilled. Rather, developments in the 1980s suggest that the numbers at risk because of lack of insurance coverage for health care are increasing. It should be noted that the United States is unique among the developed economies in having based its general health insurance system on employer benefits, while providing coverage for the elderly and the poor as extensions of the Social Security system.

What lies back of the serious miscalculation, what can be learned from it, and how can we avoid the pursuit of another mirage as we seek to fashion realistic approaches to improving access for the poor to essential medical care?

A preliminary word about the numbers of people who face difficulties in obtaining medical care. Estimates range from a low of 35 to 40 million persons who are without any form of insurance to roughly double that number if one includes all those not covered by major medical policies. But even the latter figure of 75 to 80 million, or one out of every three Americans, does not exhaust all who are at risk, since most major medical policies do not provide coverage for extended nursing home and home care services. Perhaps as many as half of all the elderly would be unprotected should they require such care for an indefinite period; this would bring the total number at risk to close to 100 million, or two out of five in the population.

The recent commitment of both the administration and Congress to amend Medicare by adding catastrophic coverage and the growing conviction among many leadership groups of the need to explore alternative mechanisms for financing long-term care point up one focus of current health policy debate. One must note, however, that even if Congress enacts catastrophic coverage for Medicare beneficiaries, as appears likely, patients requiring long-term care and patients with acquired immunodeficiency syndrome will still not be eligible for Medicare coverage.

Another policy direction that has moved to center stage involves the multiple efforts that are under way to provide insurance coverage for the 35 to 40 million who currently lack it. In its Consolidated Omnibus Budget Reconciliation Act of 1985, Congress mandated that employers must offer discharged workers (and their dependents in the event of their death) the option to convert at the group rate to an individual policy providing the same benefits; the duration of this coverage is 18 months for the employee and 36 months for survivors. Oregon has taken the lead to help small establishments provide insurance coverage for their employees through the use of subsidies. New York and New Jersey have enacted categorical programs enabling groups with specific medical conditions to obtain coverage (New York's cystic fibrosis program and New Jersey's provisions for children with catastrophic illness are examples). In some states, Blue Cross continues to provide an open enrollment period using community rating for individuals and small groups.

Such data as are available about these various state efforts to extend the reach of insurance coverage to individuals and small employers indicate that they face formidable hurdles because of the progressive "fracturing" of the insurance pool, resulting from the fact that most large and many medium-sized employers are now self-insured. The cost of covering those previously excluded is just too high.

Another approach being explored at both federal and state (Hawaii, California, and Massachusetts) levels is legislation requiring all employers to provide health insurance for their regular work force. A revised version of Governor Dukakis' legislative proposal has been passed in Massachusetts, but Senator Kennedy's comparable bill has little prospect of enactment by Congress.

From Conservation of Human Resources, Columbia University, New York.

Reprint requests to Conservation of Human Resources, Columbia University, 2880 Broadway, New York, NY 10025 (Dr Ginzberg)

been the regular mailing of checks to Social Security beneficiaries.

Someday, if the federal government succeeds in getting its budget back into reasonable balance, it may be able to force or provide incentives for the states to shore up their Medicaid programs so that they come closer to providing broad access for their poor and near poor.

The heart of the challenge to the concerned leadership lies in working toward a number of short- and longer-term reforms that would improve access to medical services for the poor. We are not likely to see the quick establishment of a federal-state insurance system that would provide all persons, including the poor, with financial entitlement to health care. The United States will have to undergo a long, and possibly bitter, political debate before reaching that goal. In the interim, we must try to improve the current, highly flawed situation, where lack of money often translates into lack of health care services. Financial entitlement to care remains a long-term objective.

In the near term, there are things that we can and should do. In many states, physician reimbursement for Medicaid patients is so low ($11 per visit in New York) that only a small minority of physicians, and surely not the best trained, treat them. Admittedly, many concerned and competent physicians continue to provide services for the poor without regard to the patient's ability to pay, but the number of poor who require inpatient and outpatient care far exceeds the philanthropic potential of physicians, hospitals, and nursing homes.

My suggestion is to move along three related fronts simultaneously: to redirect the flow of ambulatory Medicaid patients from hospital emergency rooms to private practitioners; to bring the per-visit fee to a reasonable level; and to use powerful professional and even governmental pressures to encourage physicians to treat reasonable numbers of the poor.

Similarly, a two-phased effort is required to reduce the concentration of the poor in public hospitals, even while these hospitals should be provided more resources to enable them to offer an acceptable level of care. With a surplus of acute-care beds, there are opportunities in many communities to shift hospital care for the poor into mainstream institutions. At the same time, it appears that the most effective short-term mechanism to facilitate this process would be federal and state reimbursement policies favoring hospitals that provide a large volume of charity care.

The thrust of my analysis has been to highlight the inherent limitations in a nonegalitarian society of continental proportions to establishing a single acceptable level of care for all its population and the inability to achieve this goal by passing more laws and appropriating more money, although some new laws and more money are definitely needed. The most important lessons, at least for the short run, are these: more physicians must be encouraged (not coerced) to treat the poor and more of the poor need to be treated in mainstream community and teaching hospitals. Most importantly, the members of the medical profession must take the lead to persuade those who need to be persuaded at federal, state, and local levels that the ethic of medicine requires that all men and women have access to essential care, even if the wealthy are able to command and obtain more.

Eli Ginzberg, PhD

Grateful acknowledgment is made to The Robert Wood Johnson Foundation for their support of the health policy studies of Conservation of Human Resources.

Commentary/Caring for the Poor

Unconscious on a Corner . . .

THE POLICE brought Mr W. to the emergency room. They had found him unconscious on a corner in Washington, DC, one more drunk littering the city, disturbing our view. Fifty-two years old, black, dressed in rags, homeless, he was no different from the countless other tragedies that find their way to the ER. But Mr W. was not drunk. His jaw had previously been broken and—at another emergency room—wired shut to heal, whereupon he had been discharged back to the streets. He couldn't eat or drink enough to keep himself going, and so it was that the police found him, severely dehydrated, unconscious, close to death.

For editorial comment see p 3157.

Mr W. was initially rehydrated with intravenous solutions, but his condition deteriorated, and he was readmitted to the intensive care unit. Tests were ordered, examinations repeated, consults held. At last it was clear: Mr W. had the syndrome of inappropriate antidiuretic hormone secretion with life-threatening hyponatremia. Fluids were limited to 800 mL per day, his physicians went out of their way to find demeclocycline (an expensive medication not routinely available at the hospital), and Mr W. was slowly and painstakingly nursed back to health.

Without reference to the chart, his physicians explained to me in detail his prognosis and continuing treatment; clearly they knew their patient well. Mr W. would be returning to a city shelter in a few days and the medical team would follow him up in the outpatient clinic. And as I reviewed the chart, I was impressed with our city hospital. Compassionate, competent care had obviously been rendered this homeless man without reference to his finances, social class, or culture. In my work with the poor, I was used to stories that ended differently; Mr W.'s story gave me hope for the wounded of our society.

As I walked into Mr W.'s room, however, my hopes dimmed. I was shocked by his emaciation, by the emptiness in his eyes, by the light slowly but definitely extinguishing. He was confused. Now "ready for discharge," he could not remember the day of the week, the month, or even guess the year; he seemed unaware he was in a hospital. Clearly Mr W. was demented.

How could he be discharged to a shelter? How would he manage to take his medicines if he couldn't even remember the day of the week? How would he limit his fluid intake if he couldn't understand instructions? How could these obviously compassionate physicians send this man back to an overnight shelter from which he would be sent out into the street to forage for himself every day? Mr W. had been well treated initially; why was he being abandoned now that his treatable condition had been corrected?

I talked to his physicians, trying to understand. No, they didn't really know what the shelters were like. They didn't know that there was essentially no supervisory staff, that meals were unavailable, that ten men would be herded together in one room shared with cockroaches and other vermin, that alcoholism and random violence were uncontrollable. Without a conscious decision, it has become policy in our city to consider overnight shelters as places of disposition for emergency rooms, jails, prisons, and hospitals. I could hardly blame Mr W.'s physicians for following usual policy.

The issue, however, was deeper. When Mr W. first entered the hospital, there was indeed something that his physicians could *do* for him. They had the knowledge, they had the resources, and they could *do some good*. But now that time was over and he was "cured." There were no more diseases to treat. Furthermore, there was no place to send him. In Washington, nursing home placement for the indigent can take over six months, and the physicians knew there would be intense pressure to discharge their patient from his expensive hospital bed. They knew no other options. So, their honest compassion had no place of expression and they had withdrawn. They hardened themselves to the reality of Mr W.'s plight and talked about discharge to a shelter as if that were a legitimate plan for a demented old man who needed constant supervision.

Are not many of us like Mr W.'s physicians? Within us are deep wells of compassion that—given the right set of circumstances—can be tapped to generate enormous generosity and creativity. But the truly broken—the chronically schizophrenic, the alcoholic, the homeless, the very poor—seem beyond our caring. Their needs are overwhelming, the structures that reach out to them so few. We don't know what to do, and so we turn away, offering nothing. Compassion is exiled.

After four years of working in the inner city, it is clear to me that medicine has largely abandoned the poor. Private medicine in Washington is inaccessible without insurance cover-

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From Community of Hope Health Services and the Christ House Medical Recovery Shelter, Washington, DC.

Reprints not available.

age. We called at random 50 private primary care physicians; less than half accept Medicaid for payment. Fewer than 10% have any provision for reducing fees or for deferred payment for uninsured, indigent patients. Unless one can pay the $75 to $150 office visit fee in advance, there is simply no way to get in the door.

And so the poor must rely on the public sector, on the good will of a society that has no use for them. Government budget cuts are no longer news, and an aging, fragmented bureaucracy delivers distinctly second-class care.

The reasons are multiple and complex, but the final reality is painfully obvious. The poor are denied access to adequate health care. Every day we see the scars among our patients: an ataxic, demented alcoholic who can barely balance with a walker is discharged to live on the streets; a hypertensive woman suffers a stroke because she cannot afford her medicines; a one-legged man with the remaining foot frostbitten is discharged from an emergency room with instructions to soak what is ultimately shown to be osteomyelitis. What has happened? How can the richest nation in the history of the world permit such tragedies?

The "monetarization"[1] of private medical care and the inadequacy of the public system are certainly the most important reasons for the abandonment of the poor. It is difficult for us physicians to maintain our average $108 000 annual salary and still provide care to the indigent. Medicine is quickly changing from a servant profession into a business and it is the poor who are most deeply affected. And it is also easy to blame a public system in which only 31% of the poor even *qualify* for Medicaid,[2] of which bureaucracy and second-class care are the hallmarks. But there are more subtle reasons than money and an unresponsive bureaucracy for the medical abandonment of the poor.

I would suggest that it is difficult to be a highly trained physician and work with the poor. Most of us come from a different culture and do not understand, for instance, that the very poor are often so overwhelmed by the emotional, social, and financial stresses in their lives that they simply cannot comply with our evaluation or treatment. If a patient cannot articulate his history, has a fourth-grade education, compounds his hypertension with alcoholism, cannot afford laboratory evaluation or medications, is unable to return for consistent follow-up because of problems at home, and cannot afford a place to live, we who are trained to treat diseases[3] will feel at sea. The physicians who treated Mr W. could express their compassion by diagnosing and treating his rare hormonal disorder, but they were deeply frustrated by his dementia and his homelessness, by the years of despair that had left him without resources. We who are used to the efficiency and power of conventional doctoring find this new work very demanding emotionally.

Most frustrating is the absence of self-esteem among my patients. Because so many come out of generations of poverty, they *know* that they have little value in our society; it has been demonstrated to them over and over again. There is little sense that anything they can do will make a real difference in their lives.

And so, too often my medicine doesn't work; my attempts at care fail completely. Often I feel that the most I can do is be present, be there when I can, help a little, and try to keep my own head above water. There is little sense of accomplishment for me as a physician, and I become discouraged.

There is a deeper reason, too. To work with the very poor—especially the inner city poor—is often to work with people who are very broken. Even the children have such wounds at 7 and 8—or even at 2 or 3—that a normal life would be a miracle. Some of these people will never be healed, if by "healed" one means becoming a functioning member of society.

It is not easy to open ourselves to the pain, suffering, and vulnerability of the poor. We have to confront our own limitations. We know that it does little good to offer a medication when our patient needs a home, a meal, a family, love, money, and a thousand other things that we ourselves take for granted. We also confront the limitations of a society that refuses to accept responsibility for its broken ones. And so it is tempting to turn away, offering nothing, sparing ourselves the deep frustration.

The medical abandonment of the poor thus becomes a paradigm for society's refusal to face its own brokenness. We herd the poor into ghettos so that we do not have to face our own vulnerability, our own dark sides. Our own woundedness can thus be denied for a little longer while the sores fester unseen in "those others." Sölle[4] has suggested that when we thus participate in injustice without struggling against its inhumanity, we are overcome by an "objective cynicism" that leaves us alienated and hopeless, choosing death. We find ourselves deeply wounded by our refusal to care for the poor.

What can be done? Clearly our institutions need to change. Clearly some form of national health coverage available to all the poor is required. Without guaranteed health insurance, nothing else will be of much use. But, given the current social and political atmosphere, that change will be a long time coming. There is the danger that by focusing exclusively on what needs to happen in the political system, we will avoid the deeper, more personal transformation that is also necessary.

Can we who are in private medicine open, say, 15% of our practice to those who cannot afford the full fee? Can we accept Medicaid—with all its paperwork, discounts, and headaches—joyfully as an opportunity to participate with our society in ministry to the poor and oppressed? Can we who belong to medical institutions press our employers to do the same?

The first step must be to bring the poor into our practices. In our city, over 200 private consultants—coordinated by the Archdiocese of Washington—have volunteered to serve as a referral network for indigent patients; radiology and laboratory services have been similarly offered. It is only a beginning, of course, but it opens us to the possibility.

I am beginning to realize that we in medicine need the poor to bring us back to our roots as a servant profession. Medicine drifts understandably yet ominously toward the technical and the economically lucrative, and we find it difficult to resist. Perhaps we *need* the poor at this very moment to bring us back to ourselves. The nature of the healer's work is to be with the wounded in their suffering. Can the poor in their very vulnerability show us how?

David Hilfiker, MD

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2. *No Room in the Marketplace: The Health Care of the Poor.* St Louis, Catholic Health Association's Task Force on Health Care of the Poor, 1986, p 2.
3. Baron R: An introduction to medical phenomenology: I can't hear you while I'm listening. *Ann Intern Med* 1985;103:606-611.
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Editorial

Fifty Hours for the Poor

This editorial also appears in the December issue of the ABA Journal, The Lawyer's Magazine.

Doctors, lawyers, and the clergy belong to the classic learned professions, which are historically distinguished from trades and businesses. Although this distinction has blurred in modern times, one of the characteristics of a true profession remains its special relationship with the poor.

See also p 3155.

Edmund Pellegrino, director of the Kennedy Institute of Ethics, states that a fundamental difference between a business and a profession is that "at some point in the professional relationship, when a difficult decision is to be made, you can depend on the one who is in a true profession to efface his own self-interest."

The privilege to practice law or medicine has carried with it the obligation to serve the poor without pay. Doctors and lawyers today have tended to become overly concerned with their professional incomes and practice efficiencies, but they must not forget their higher duties. Many members of our professions have always cared for the poor who need legal or medical help. But their efforts are not what they should be, and there is abundant evidence of unmet needs. For example, 35 to 50 million Americans are now believed to be medically uninsured or seriously underinsured; access to health care is widely considered to be in crisis. For 68% of legal problems encountered by poor people, the services of a lawyer are not used, according to the American Bar Foundation.

The philosophical and ethical roots of the medical and legal professions are entwined with the public interest, service to the community, and caring for the poor. These professions maintain those values. In law, the official policy of the American Bar Association, adopted in 1975, states:

> It is a basic professional responsibility of each lawyer engaged in the practice of law to provide public interest legal services without fee or at a substantially reduced fee in the following areas: poverty law, civil rights law, charitable organizations representation and administration of justice. It should always be provided in a manner consistent with the Model Rules of Professional Conduct. The organized bar should assist each lawyer in fulfilling his responsibilities in providing such services as long as there is need, and should assist, foster, and encourage governmental, charitable, and other sources to provide public interest legal services.

In medicine, the American Medical Association's original code of ethics, written in 1846, emphasizes relief of pain and diseases without regard to danger or personal advantage and states that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded." In 1987, the American Medical Association House of Delegates approved as policy: "That the AMA urge all physicians to share in the care of indigent patients." Principle 3–6b of the Health Policy Agenda for the American People states that, "All health care facilities and health professionals should fulfill their social responsibility for delivering high quality health care to those without the resources to pay."

How many members of the legal and medical profession now deliberately care for the poor in a voluntary and uncompensated way? Many, but not enough. What percentage of their time is spent doing so? Much, but not enough. Accompanying articles in this issue of both the *ABA Journal* and *JAMA* explore these questions in some detail.

Doctors and lawyers in our society have benefited greatly from the abundant opportunities made available to them from the fruits of our plenty. We believe that all doctors and all lawyers, as a matter of ethics and good faith, should contribute a significant percentage of their total professional efforts without expectation of financial remuneration. This percentage will vary depending on time, setting, opportunity, and need, but all should give something. This is the proper behavior of a learned professional. We believe that 50 hours a year—or roughly one week of time—is an appropriate minimum amount.

There is a great tradition behind the giving of this gift. In the church, it is called *stewardship*. In law, it is called *pro bono publico*. In medicine, it is called *charity*. In everyday society, it is called *fairness*.

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June 30, 1988

Testimony Presented To Senator John Heinz Regarding Needs of Patients Without Health Insurance Coverage

As a hospice, we are all too familiar with the problem of reimbursement under the current insurance systems; but a larger, very real problem is felt by the people we serve who are under-insured or uninsured. As an agency, we care for any terminally ill patient regardless of their ability to pay. Over the years, we have seen many people devastated not only by illness but also by financial ruin. These people were very much like you and I prior to becoming ill. The majority with such problems fall into the young and middle age range who have lost their incomes and insurance due to illness.

Following are 3 such examples:

A 34 year old divorced mother of 3 young children. She lost her job and insurance after being diagnosed with a brain tumor. She did become eligible for Medical Assistance and Welfare monies. Unfortunately, there are many medical items not covered and welfare barely pays enough to run a household. Could you imagine falling into the category of poor just because you are ill? Try to explain to your young teenagers not only that you are not going to get better but also that they can no longer buy the everyday luxuries that they are used to. This womans last two months of her life were spent in our Inpatient Unit at no charge and no reimbursement. Through her church and other local charities help was given to get the family through these times. What would have happened to her and her children if she had not been linked to helping agencies.

A second example is a 42 year old man with a wife and 2 young children. When he first became ill with facial cancer they lived off their savings, draining it down to nothing. He did eventually get disability and after 2 years of being ill, Medicare. During the time before this, though, he

A Division of Lutheran Welfare Service of Northeastern Pennsylvania, Inc.

had medications that cost well over $50.00 a week and needed medical equipment which made it possible for him to be at home. His wife was unskilled and now could not look for a job because he could not be left alone. Again as a hospice, we linked them to private community agencies that could help. The children were given new shoes and clothing, a money and food drive was started, an equipment company donated needed medical equipment and the children received Christmas presents through kind-hearted people. Again, what if these people did not get linked to an agency that could help care for this man and also link him to others that could help?

A third and last example is a case of a 12 year old boy. He was being raised by a single parent and was diagnosed as having a terminal brain tumor. He was a very sick boy, who, among other things, needed a hospital bed, tube feedings, and diapers just to remain at home for awhile. He too had Medical Assistance but none of the above mentioned items are covered. Are you aware that the monthly rental of a hospital bed could equal or exceed the amount of a bi-monthly Welfare check? Once again, through local charitable organizations and an equipment company who donated the medical equipment, he was able to be at home for awhile. He too spent much of his last days at our Inpatient Unit with no charge and no reimbursement for us. Imagine the emotional devastation of knowing you are losing your child and the frustration of not knowing if you can provide for him to make his last months more comfortable.

I'm sure there are many people out there who are unaware of what charitable institutions are in their community. Even if they are, these institutions too have limited funds for people, therefore should it be their responsibility to help pay for medical equipment, supplies, tube feedings, diapers, medications, and nursing care? If people had insurance to cover these needed medical items, charitable organizations could better help with monies needed for day to day living.

Respectfully submitted,

Joyce Wizda

Joyce Wizda, MSW
Social Worker

TESTIMONY OF SHARON McCRONE, EXECUTIVE DIRECTOR, EMPLOYMENT OPPORTUNITY TRAINING CENTER OF NORTHEASTERN PENNSYLVANIA BEFORE U.S. SENATOR JOHN HEINZ

The Employment Opportunity Training Center (EOTC) of Northeastern Pennsylvania operates the Women's Employment Program to assist Lackawanna County residents who receive Aid to Families with Dependent Children (AFDC welfare) to obtain and retain permanent employment.

Since it began in 1986, the Women's Employment Program (WEP) has been assisting primarily women who have multiple barriers to employment. WEP's success rate is evidenced, in part, by a placement rate of 70% and a retention rate of 87% of those employed. Our experience over the past three years of working toward employment placement/retention has clearly indicated the necessity for adequate medical coverage for all employees.

Because the majority of people we serve have the sole responsibility for raising their children, they must have access to affordable medical care. Since many of the jobs that are available to them do not provide such employer-paid benefits, they are forced to continue receiving AFDC welfare and its attendant health care provisions in order to ensure that their children's health needs are properly met.

In order for WEP participants to accept a position, medical coverage for themselves and their children must be included in an employer's benefit package. Those participants who accept employment without such coverage do so because they are willing to risk the initial commitment with the understanding that the needed coverage will be available to them after a certain length of employment.

Legislation such as that outlined in Senate Bill 1265 (Minimum Health Benefits for All Workers Act) would greatly increase employment opportunities for WEP participants and would significantly improve the quality of their lives, their families' lives, and the community in which they live and would be working.

Also to be considered is a transitional period duing which AFDC recipients could receive medical assistance until affordable medical coverage could be provided by the employer.

TESTIMONY OF THE NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION ON EXPANDING HEALTH INSURANCE COVERAGE, BEFORE THE SENATE FINANCE SUBCOMMITTEE ON HEALTH

Mr. Chairman and members of the Subcommittee, I am pleased to testify before you on proposals to expand health insurance coverage. My name is Bob Bergland, and I am the Executive Vice President of the National Rural Electric Cooperative Association. NRECA is the national service organization of the approximately 1,000 rural electric service systems operating in 46 states. These systems serve over 25 million farm and rural individuals in 2,600 of our nation's 3,100 counties. Various programs administered by NRECA provide pension and welfare benefits to over 125,000 rural electric employees, dependents, directors and consumer-members in those localities.

Our special concern is with the enhancement of life in rural areas. Rural communities are particularly dependent on smaller firms, both for employment and for the supply of needed goods and services. The critical state of many rural economies requires that the needs of small firms and their employees be explicitly considered in public policy decisions.

We recently commissioned a study comparing health coverage and access in smaller firms with the rest of the economy. The study was entitled, "The NRECA Survey of Health Coverage in Smaller Firms: Evidence and Policy Implications." It was based on a survey of health coverage and decision-making in 822 small businesses. The survey was designed to discover the prevalence of health coverage, the type of coverage offered, who pays for coverage, and how employers make decisions about their health insurance needs. While it focused specifically on small rural firms, many of the study's conclusions would apply to small firms everywhere.

HEALTH COVERAGE NEEDS IN SMALLER FIRMS

My remarks today will highlight the study's major findings. With your permission, the full text of the study will be inserted in the record of this hearing.

Our study found significant health coverage needs in small rural businesses. Nearly four out of every ten employees in small rural firms do not have access to employer-sponsored health coverage, compared with fewer than two out of ten employees nationwide, and fewer than 1 out of ten in medium and large firms.

The greatest coverage gaps are in the smallest firms. Firms with fewer than 10 employees accounted for 23 percent of the employees we studied but 46 percent of the noncovered workers. Firms with fewer than 10 employees accounted for 72 percent of the firms studied, but 88 percent of the firms without health coverage.

When smaller employers do offer coverage, their plans lack some of the safety net features available in larger employers' plans. In particular, retirees and dependents in rural areas are less likely to be eligible for coverage than nationwide. While three out of four covered employees in medium and large firms are in plans that offer continued participation after retirement, fewer than two out of four covered employees in our sample participated in such plans. Nearly 7 percent of employees in the sample participated in plans that did not cover dependents.

Employees in small firms are more likely to pay for their coverage. Labor Department data show that 43 percent of covered employees in medium and large firms contribute to the cost of their own coverage. By comparison, 57 percent of covered employees in smaller rural firms paid all or part of the premiums for their coverage. In particular, one in five covered employees in firms with fewer than five employees pays the entire cost of the plan.

Health coverage increases as small firms mature and become more established. The share of employers offering coverage increased from 40 percent of those in business two years or less to nearly 70 percent of those in business 20 years or more. The largest increase in coverage occurs after an employer has been in business more than 10 years.

As a firm's economic performance improves, the likelihood that it will offer health coverage also improves. Thus, the problems facing rural economies are probably retarding voluntary coverage expansion.

Cost is a major barrier employers face in deciding to offer coverage and their dominant consideration in choosing and changing plans. Cost barriers account for 40 percent or more of the employees without coverage. Almost 60 percent of the employers who offered health coverage cited cost as the dominant factor in the choice of plan. Of those changing health coverage providers, 40 percent did so for cost reasons.

POLICY CONCERNS

The results of our survey suggest several issues that should be considered as the Congress continues its debate over universal health coverage. These issues concern relief for the smallest firms, measures to reduce the costs of providing coverage, and ways to reduce the administrative burden of offering coverage.

Relief for Smaller Firms

The bill would permit firms with fewer than 10 employees in business for less than 2 years to delay full implementation of the minimum plan and firms with fewer than 5 employees to offer only catastrophic coverage. This relief takes these firms' cost sensitivity and lower wage scales into account, but also reduces the bill's net impact.

This relief could limit coverage for as many as 46 percent of the employees and 88 percent of the employers without coverage among small firms. As an alternative to delayed or partial implementation, smaller firms could be allowed to buy the minimum coverage at a subsidized price, or receive a refundable tax credit for part of their coverage costs.

Reducing Coverage Costs for Smaller Firms

Even with the cost-reducing features built into H.R. 2508 and S. 1265, universal coverage will increase costs and administrative burdens for smaller firms. Some of the cost burden could be reduced by extending full deductibility of health insurance premiums to the self employed. This would be fair once all employers are required to offer coverage.

Reducing Administrative Burdens

The Consolidated Omnibus Reconciliation Act of 1986 (COBRA) and the Tax Reform Act of 1986 (TRA) imposed significant administrative and record-keeping requirements on all employers sponsoring health plans. Failure to comply with these requirements, however inadvertent this failure may be, brings severe sanctions. COBRA penalties include loss of the tax deduction for all employer health plan contributions and inclusion of these contributions in income for the highly paid. Failure to comply with the documentation and reporting requirements contained in section 89(k) of the tax code is punishable by inclusion of health benefits received in employee income.

If universal coverage is enacted, some of these requirements could be simplified and the sanctions moderated, particularly for smaller firms, without impairing the goals these laws were designed to achieve. Congress is currently considering legislation that would end COBRA eligibility for former employees who become eligible for coverage under a new employer's plan. Under current law, COBRA eligibility ends only once the employee enrolls in the new plan. This change would reduce some of the burden of COBRA without reducing access to coverage.

Section 89(k)(1) of the tax code provides that plans must be in writing, employee rights must be legally enforceable, employees must be provided reasonable notification of available benefits, the plans must be maintained for the exclusive benefit of employees, and the plans must be established with the intention of being maintained for an indefinite period of time. If universal coverage were in place, coverage and eligibility requirements would be fairly standard among employers. The section 89 reporting requirements, sanctions, or both could then be modified, particularly for smaller employers. While most small employers would be exempt from the section 89 nondiscrimination tests, these costly and difficult tests could also be simplified if coverage were universally required.

CONCLUSIONS

Rural Americans need greater access to health coverage. H.R. 2508 and S. 1265 are one way this can be accomplished. We urge the Congress to consider the special needs of smaller businesses in pursuing this goal. Small businesses must be treated fairly and unnecessary complications must not be placed in their way.

We would be pleased to work with the Committee as it considers this issue. Thank you.

THE NRECA SURVEY OF

HEALTH COVERAGE IN SMALLER FIRMS: EVIDENCE AND POLICY IMPLICATIONS

A Report to the
National Rural Electric Cooperative Association
June, 1988

INTRODUCTION

This report examines the results of a recent survey of health coverage among small rural employers conducted by the National Rural Electric Cooperative Association (NRECA). The report uses these results to examine the potential impact of universal health coverage initiatives on smaller employers, and policy concerns affecting smaller employers in the universal coverage debate.

The NRECA Survey

In late 1987, the NRECA commissioned a survey of the health coverage offered by small employers in NRECA service areas.[1] The survey was designed to discover the prevalence of coverage, the type of coverage offered, the distribution of health coverage costs between employers and employees, and how employers make plan decisions. This report concludes that health coverage patterns in small rural firms differ significantly from the nation as a whole.

The Minimum Health Benefits for All Workers Act

On February 17, 1988, the Senate Committee on Labor and Human Resources passed The Minimum Health Benefits for All Workers Act (S. 1265), which would require all employers to offer a minimum package of health coverage benefits to all adult employees working more than 17.5 hours per week and their dependents (for detail on the benefits required in the bill, see Table 1). Employees would generally be eligible for coverage no later than 30 days after beginning employment.[2]

Employers would be required to pay at least 80 percent of the premium for the minimum benefit plan, rising to 100 percent for workers with incomes under 125 percent of the minimum wage. Employers offering a more generous plan than the minimum specified could require higher deductibles, coinsurance payments, or employee contributions, as long as the employer's contribution was actuarially equivalent to that required under the minimum benefit plan.

The bill contains provisions designed to ease the burden of the requirements on small businesses. Employers with fewer than 10 employees who have been in business less than two years would have to offer employees only a low-cost catastrophic plan to cap out-of-pocket medical costs. Employers with fewer than 5 employees could phase in coverage over five years, but would have to provide catastrophic coverage after three years.

Small employers' costs would also be reduced through the establishment of regional insurance pools. All businesses

Table 1.

Provisions of the Minimum Health Benefit Plan
Under S. 1265

Benefits:

- Catastrophic provision limiting out-of-pocket costs to $3000 per year per family.
- No exclusions based on health status or pre-existing conditions.
- Mental-health benefit covering at least 45 days of inpatient care and up to 20 outpatient visits annually. Employees could be required to pay 50 percent of the costs of outpatient care.
- State-mandated benefits would not be included in the minimum package.

Cost Sharing:

- Coverage of 100 percent of costs of prenatal and routine well-baby care. No deductible could be imposed for these benefits.
- Coverage for at least 80 percent of cost of medically necessary hospital and physician care and lab tests (that is, employee coinsurance would be limited to 20 percent).
- Deductibles would generally be limited to no more than $250 per individual and $500 per family.
- Employers would pay at least 80 percent of the premium cost of the minimum benefit plan, and 100 percent of the premium costs for employees with incomes under 125 percent of the minimum wage.

Employee Eligibility:

- Employees generally eligible for coverage no later than 30 days after employment.
- No eligibility or coverage limitations to be imposed on the basis of health status or pre-existing conditions.

Small Firm Relief:

- o Small and new firms would be allowed to phase in coverage, offering only catastrophic coverage initially.

without coverage on the law's effective date would be required to buy coverage from the regional insurers. Businesses with fewer than 25 employees would be allowed but not required to buy through the pools if they have coverage on the effective date, but would be required to buy through the program upon changing insurers. Currently, an estimated 25 percent of small employers' premiums covers sales expenses, administrative costs, and profit.[3] The regional insurer structure is expected to reduce this share to 15 percent.

The NRECA survey provides several unique resources for the health coverage debate. It is the first survey of small employers to focus on the rural population. The critical state of many rural economies requires that the needs of rural employers and their employees be explicitly considered in this debate. Despite the survey's rural focus, however, the problems and concerns it identifies are largely common to small firms everywhere.

The survey also provides new information on the decision-making process of small employers. Most available data on health coverage can only examine existing coverage patterns, and cannot tell us anything about how these patterns came to be.

This report begins with a description of the NRECA sample and the population from which it is drawn. The report then covers four topics:

- o Who is covered in rural areas;
- o Why employers adopt coverage and choose plans;
- o Who is not covered and why not; and
- o The survey's implications for public policy decisions on health coverage.

THE NRECA SAMPLE

The NRECA sample consists of employers with 60 or fewer employees in seven states (Table 2).[4] The 822 employers in the sample, with an estimated 7930 employees, were drawn from a group of over 94,000 small employers and an estimated 900,000 employees in five industrial categories.

The seven sample states account for 19.3 percent of the nation's rural population.[5] The residents of these states are more likely to live in rural areas, more likely to be employed by small businesses, and less likely to have employer-provided health coverage than the rest of the nation. While 23.5 percent of the U.S. population lives in nonmetropolitan areas (as defined by the U.S. Office of Management and Budget), six of the sample states are from one-third to nearly three-quarters rural. In the nation as a whole, 66 percent of the nonelderly employed population is covered through an employer-provided plan, either

Table 2.

Employer-Provided Health Coverage Rates
and Nonmetropolitan Population
in NRECA Sample States, 1985
(in percents)

State	Employer Health Coverage	Nonmetropolitan Population
Colorado	68.1	18.8
Georgia	65.2	36.1
Kansas	69.2	49.9
Kentucky	62.0	54.5
Mississippi	57.6	70.6
Oklahoma	59.0	41.7
Tennessee	60.9	33.4
United States	66.0	23.5

Source: Author's compilations based on Employee Benefit Research Institute (EBRI), "A Profile of the Nonelderly Population without Health Insurance," EBRI Issue Brief No. 66, May 1987, and U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States 1987, Table 33.

as an employee or as a dependent of an employee.[6] Of the sample states, only two states have employer-provided coverage rates that meet or exceed the national rate.

THE COVERED POPULATION

Employees in rural small businesses are significantly less likely to have access to employer-provided health coverage than the workforce as a whole. Nationally, 82.5 percent of all employees and 95 percent of full-time employees in medium and large firms (generally 100 employees and larger, depending on the industry) are covered by an employer-sponsored plan (Table 3 and Figure 1). By comparison, 64.7 percent of the employees in the NRECA sample were covered by an employer-sponsored plan.

Part-time employees are somewhat more likely to be covered in smaller rural firms than nationwide.[7] In the NRECA sample, 22.6 percent of those covered were in plans that covered part-time employees (Table 3). By comparison, 19.5 percent of all part-time employees nationwide receive direct coverage from their employer. This difference could reflect the fact that smaller

Table 3.

Health Coverage Rates and Cost-Sharing in Rural Small Firms Compared with National Totals (in percents)

Group	Rural Small Businesses	National Totals
Employees participating in plans	64.7	82.6 to 95.0 a/
Percent of participants in plans covering:		
Part-time employees	22.6	19.5 b/
Dependents	93.3	100.0 c/
Retirees	46.9	76.0 c/
Who pays premiums (employee coverage):		
Employer	43.6	56.8 c/
Employee	8.0	d/
Shared	48.8	43.2 c/

Sources: Rural data from NRECA survey. National totals from: U.S. Department of Labor, Bureau of Labor Statistics (BLS), Employee Benefits in Medium and Large Firms, 1986 (Washington, D.C.: U.S. Government Printing Office, 1987); and Employee Benefit Research Institute (EBRI), "A Profile of the Nonelderly Population without Health Insurance," EBRI Issue Brief No. 66, May 1987, as noted.

a/ The lower figure includes all workers covered directly or indirectly (EBRI); the second figure includes only full-time workers in medium and large firms covered directly (BLS).

b/ Employees are considered part-time if they worked less than 35 hours in a typical week. This figure represents the share of all part-time workers reporting direct coverage from an employer (EBRI). Some part-time employees with direct coverage available to them may instead be covered through a family member's plan and would not be counted in this total.

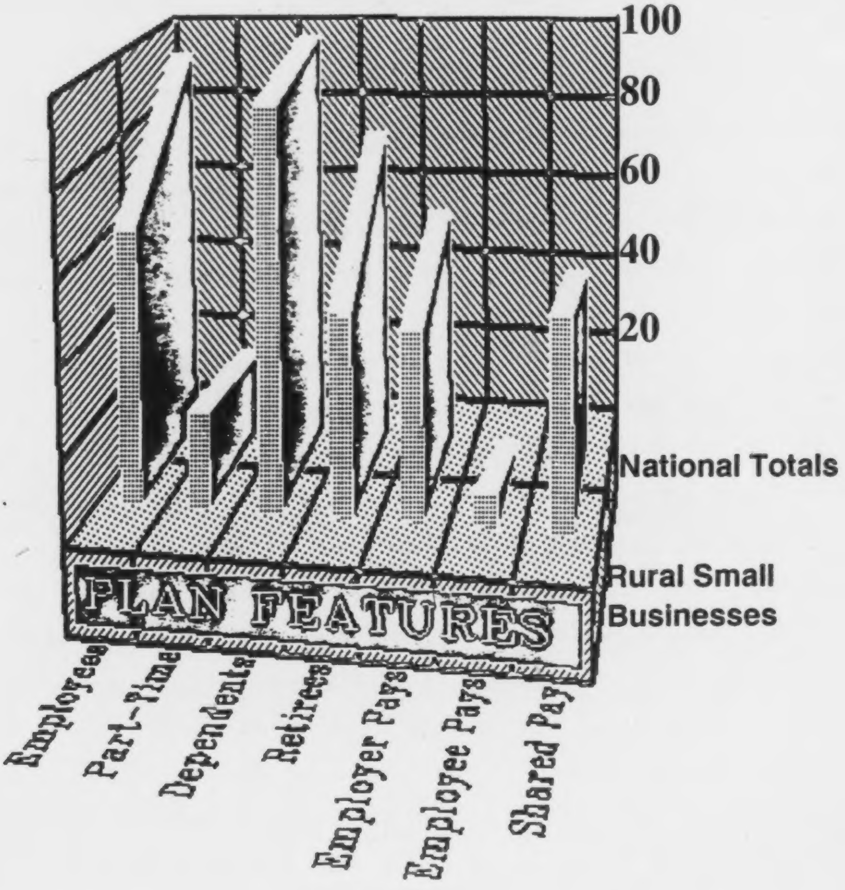
c/ BLS data.

d/ These plans are not included in the BLS survey. Other survey data suggest that fully employee-paid plans are relatively uncommon (see text).

FIGURE 1.

Health Coverage Rates and Cost Sharing Rural Small Firms Compared with National Totals

(in Percents)



firms that do not buy coverage at community rates may need to cover part-time employees to achieve a risk pool of adequate size.

Dependents' coverage is almost universally available in medium and large firms that offer coverage, though an employee contribution to such coverage is usually required. Nearly 6 percent of covered employees in smaller rural firms are in plans that do not provide for dependents' coverage (Table 3).

Retirees are much less likely to be eligible for coverage in smaller rural employers' plans than nationwide.[8] BLS data show that 76.0 percent of covered employees participate in plans that offer continued participation after retirement. By comparison, 46.9 percent of covered employees in the NRECA sample participated in such plans.

The share of employers requiring employee contributions to premium costs has been increasing in recent years, but smaller rural employers are ahead of this trend. Employees in smaller rural firms are more likely to contribute to their coverage when it is available. BLS data show that 43 percent of covered employees contributed to the cost of their own coverage (Table 3).[9] By comparison, 56.8 percent of covered employees in smaller rural firms paid all or part of the premiums for their coverage.

The most dramatic difference in cost-sharing between rural firms and others is in the proportion of employees paying the entire cost of their coverage. The BLS survey does not consider employee-paid coverage an employer-provided benefit, and thus does not tabulate the percentage of employees in this category. Other data sources suggest, however, that employee-paid plans in medium and large firms are rare.[10]

Just as smaller firms differ from larger ones, they also differ from each other. Coverage rates increase with firm size (Table 4 and Figure 2). Coverage rates are lowest in firms with fewer than five employees: 35.6 percent of employees in firms with one to four employees are covered by health coverage plans, compared with 58.7 percent in firms with five to nine employees. In firms with 25 to 60 employees, 73.2 percent of employees are covered by an employer plan. This is double the coverage rate in the smallest firms, though still below national coverage rates.

Table 4.

Coverage Rates by Participant Group and Size of Firm
(In Percents)

	Size of Firm			
Participant Group	1 to 4	5 to 9	10 to 24	25 to 60
Full-time employees	35.6	58.7	63.9	73.2
Part-time employees a/	18.6	28.7	17.0	24.4
Dependents a/	79.1	88.3	94.7	95.1
Retirees a/	19.2	19.1	34.0	61.0

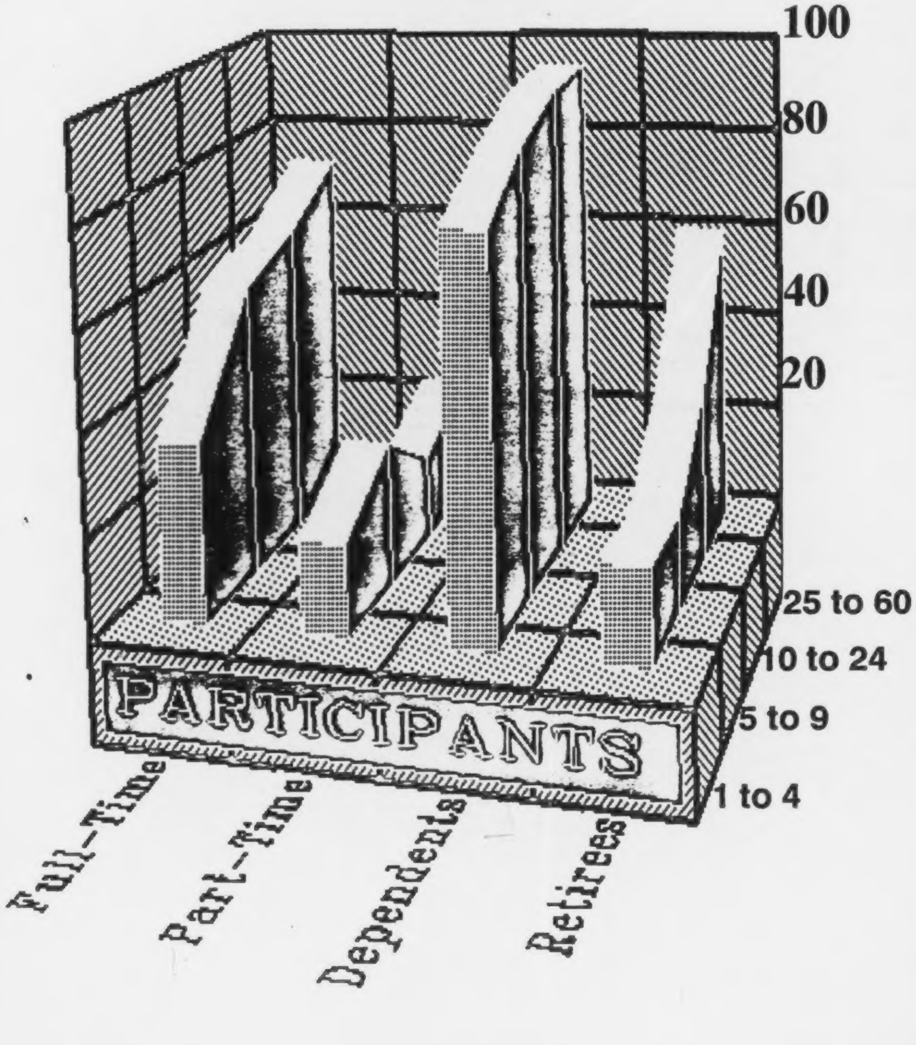
Source: NRECA Survey.

a/ Percents represent the share of full-time employees covered under plans in which the designated groups are eligible to participate. If the respondent did not indicate whether a particular group was eligible to participate, that employer's plan was treated as not including the designated group.

FIGURE 2

Coverage Rates by Participant Group and Size of Firm

(In Percents)



Many employees are covered by employer-sponsored health plans through another employed family member, generally a spouse. In 1985, nearly 20 percent of all employees with employer-provided coverage were covered indirectly.[11] Since the NRECA survey was based on interviews with employers, evidence on the availability of indirect coverage is not available. However, dependents' coverage is less prevalent in small firms than in larger employers' plans. To the extent that rural areas are more dependent for employment on smaller firms, this suggests that, at least in rural areas, secondary coverage may be less available as well. This may make lack of employer-provided coverage a more serious problem.

Coverage rates differ considerably among rural industry sectors. The lowest coverage rate in the NRECA sample was observed in retail trade firms, with 45.0 percent of employers offering a health coverage plan (Table 4). By contrast, 81.5 percent of employers in finance, insurance, and real estate offered health coverage. While manufacturing tends to be a high-coverage sector nationwide,[12] slightly more than half of rural manufacturing firms in the NRECA sample offered health coverage.

As a smaller firm becomes more established, it is more likely to offer a health coverage plan. The share of employers in the NRECA sample offering coverage increased from 40.3 percent of those in business two years or less to 69.3 percent of those in business 20 years or more (Table 5). The largest increase in coverage rates occurs after an employer has been in business more than 10 years. The proportion of employers offering coverage rises from 48.2 percent of those in business 6 to 10 years to 64.2 percent of those in business 11 to 20 years, for an increase of 25 percent.

WHY DO EMPLOYERS OFFER COVERAGE?

Employers offer coverage because they feel they need to do so. Three of the top four reasons for offering coverage could be considered market or competitive reasons: the fact that coverage is part of the benefits package, the employer's perception that employees need coverage, and the need to compete for good employees (Table 6).

Costs and related considerations, in turn, were the three least important reasons employers cited for offering coverage. Fewer than 3 percent of employees were covered by employers who cited getting coverage or group rates for plan founders or better rates for employees as the reason for offering their employees coverage.

THE ROLE OF COSTS IN EMPLOYER DECISION-MAKING

Costs influence both the employer's choice of plans and the decision to change plans. Almost 60 percent of the employers who offered health coverage cited cost as the dominant factor in the

Table 5.

Health Coverage Rates Among Employers
by Industry and Age of Firm
(in percents)

Firm Characteristic	Employers Offering Health Coverage
Industry:	
Manufacturing	58.7
Wholesale trade	76.7
Retail trade	45.0
Finance, insurance, and real estate	81.5
Services	58.7
Age of firm:	
2 years or less	40.3
3 to 5 years	45.3
6 to 10 years	48.2
11 to 20 years	64.2
20 years or more	69.3
All firms	56.3

Source: NRECA Survey.

Table 6.

Employees and Employers With Health Coverage by Employer's Reason for Offering Coverage (in percents)

Reason	Employees	Employers
Part of the package	31.9	31.5
Employees need coverage	30.5	29.0
Moral obligation	19.0	12.9
To compete for good employees	13.0	12.2
To have a healthy, productive workforce	8.6	5.2
Owner wanted coverage	2.7	7.2
To get group rates for company founders	2.3	1.5
To get group rates for employees	1.9	2.5

Source: NRECA Survey.

choice of plan (Table 7). Over one-third of employers chose their plan for the coverage or benefits it offered, though fewer than 2 percent cited specific features like major medical provisions or deductibles. Employers thus see cost as more important than plan features in choosing a plan, and seem to consider features as a package rather than in isolation.

Cost is also important in plan changes, and small employers are fairly mobile among plans. Nearly half of the employers offering plans reported that they had changed plans at some point, and nearly 52 percent had used their current health care provider for less than 5 years. Of those reporting that they had changed plans, 40 percent did so for cost reasons (Table 7). Policy-makers have been concerned with the administrative burden universal health coverage would impose on smaller employers. Among rural small employers who offer coverage, administrative ease was not a major factor in either the choice of plan or the decision to change plans. Only 5.4 percent of employers cited this as a factor in plan choice and 3.5 percent considered this in changing plans.

The quality of agent or company service was far more important; nearly 18 percent of employers cited this as a factor in plan choice. The quality of service could influence administrative ease, reducing employers' burden of maintaining plans in ways that are not easily quantified.

The importance of service to smaller employers is underscored by the fact that 45.8 percent of the sample employers

Table 7.

Employers' Major Reasons for Choosing and Changing Plans
(in percents)

Reason	Choice of Plan	Change of Plan
Cost	59.3	37.8
Coverage or benefits desired	29.9	4.1
Quality of agent or company service	17.9	5.2
Administrative ease	5.4	3.5

Source: NRECA Survey.

Notes: Respondents could cite more than one reason for each decision.

with coverage reported that they generally deal with their insurance agent on health coverage matters, rather than directly with the company or other parties. If the regional insurance pools proposed under S. 1265 reduce the quality of attention and service plan sponsors receive from health coverage vendors, employers' administrative burden of providing health coverage will increase. This increased burden could increase operating costs and offset the pools' cost advantages.

COVERAGE OFFERED BY SMALL RURAL EMPLOYERS

The plans offered by rural employers reflect their cost concerns. The NRECA data do not allow direct comparison with national patterns, since actual employee enrollment by type of plan is not known. However, rural employers are very interested in managed-care arrangements, particularly preferred provider organizations (PPOs). PPOs are networks of health care providers (doctors, hospitals, etc.) who agree to provide plan sponsors with reduced rates in return for employee referrals. Nearly 5 percent of the employees with coverage available to them could select a health maintenance organization (HMO), and nearly 7 percent could enroll in a PPO (Table 8). Nationwide, 13 percent

Table 8.

Employees With Coverage
By Type of Plan Available and Firm Size
(in percents)

Size Category	Indemnity	HMO	PPO
1 to 4	68.1	3.8	6.0
5 to 9	68.1	5.3	4.3
10 to 24	71.3	7.4	7.4
25 to 60	78.0	3.7	7.3
All firms	74.6	4.8	6.9

Source: NRECA Survey.

Notes: Employers could offer more than one response, so percents are not additive.

Data for employers who offered other plans or did not respond to the question are not displayed in the table.

of health insurance plan participants are enrolled in HMOs and about 1 percent participate in PPOs.[13]

In other respects, the provider choices of smaller rural employers resemble those of larger employers. The majority of small rural employers offer traditional indemnity plans, just as the majority of employees with health coverage nationwide are covered under such plans. Likewise, 31.5 percent of the employers in the sample used Blue Cross-Blue Shield as a carrier, while 28 percent of employees are covered under the Blues' plans nationwide.

As noted earlier, the sensitivity of smaller employers to health coverage costs promotes greater cost-sharing by employees. Employee-paid plans are most prevalent in the smallest firms. Nearly 20 percent of the covered employees in firms with fewer than 5 employees paid the entire cost of their plans, compared with 10.6 percent in firms with 5 to 9 employees and 6.1 percent in firms with 25 to 60 employees (Table 9 and Figure 3). This distribution suggests that the cost-sharing provisions in S.1265 will have their most adverse effects on the smallest firms with the lowest coverage rates.

THE POPULATION WITHOUT COVERAGE

The greatest coverage gaps occur in the smallest firms. Firms with fewer than 10 employees accounted for a larger share of the sample's noncovered population than their share of the

Table 9.

Employees With Coverage
by Premium-Sharing Arrangements and Firm Size
(in percents)

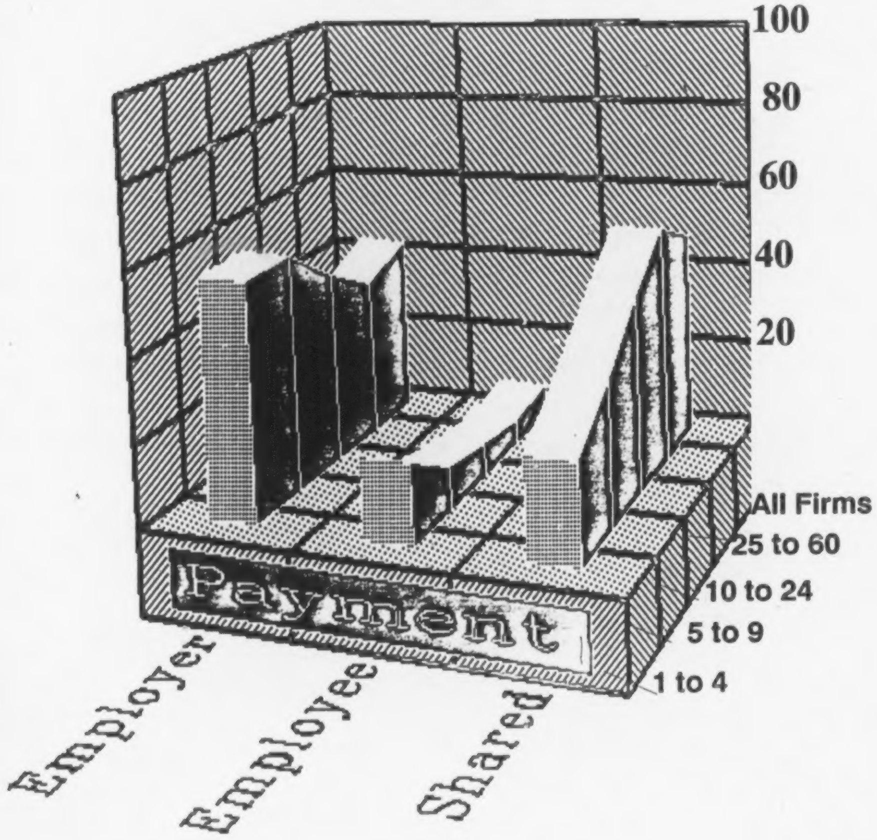
Firm Size	Employer Pays All	Employee Pays All	Cost is Shared
1 to 4	56.7	19.5	23.8
5 to 9	56.9	10.3	33.8
10 to 24	46.6	7.8	45.6
25 to 60	38.1	6.0	56.0
All Firms	43.6	8.0	48.8

Source: NRECA Survey.

FIGURE 3.

Employees by Health Coverage Premium-Sharing Arrangements and Firm Size

(In Percents)



sample's employment. These firms accounted for 23 percent of the sample's employees and 46 percent of its noncovered workers. The relative importance of these employers in the noncoverage problem is even greater when coverage is measured at the firm, rather than the employee, level. Firms with fewer than 10 employees accounted for 72 percent of the firms in the sample, but 88 percent of the firms not offering health coverage.[14]

Why Employers Do Not Offer Coverage

Employers without health coverage plans consider cost the most important barrier to offering coverage. Cost to the company was cited by 27.2 percent of the employers not offering coverage, with 29.9 percent of the noncovered employees (Table 10). Cost to the employee was cited by 3.6 percent of the employers, accounting for 12.1 percent of the noncovered employees. Cost could also contribute to other reasons for not offering coverage. For example, high employee turnover, cited by 6.5 percent of the employers without coverage, can increase the cost of offering a plan.

Table 10.

Employees and Employers Without Health Coverage by Employer's Reason for Not Offering Coverage (in percents)

Reason	Employees	Employers
Cost to company	29.9	27.2
Don't need/have alternative coverage	24.5	38.0
High employee turnover	15.3	6.5
Cost to employee	12.1	3.6
Lack of employee interest	6.8	2.9
Lack of available health care plans	0.8	2.0
Administrative burden	0.9	0.4
Other	22.5	33.2

Source: NRECA Survey.

Some employers do not offer coverage because they feel that employees do not need it, perhaps because they can get coverage from other sources. Thirty-eight percent of the employers not offering coverage, with 24.5 percent of the noncovered employees, cited this as a reason (Table 10). As discussed earlier, secondary coverage may be less available in rural areas than nationwide.

Only 2.0 percent of the employers without coverage failed to offer it because of plan availability. This could suggest the presence of marketing and information gaps, particularly since all the employers citing this reason had fewer than 5 employees.

Incentives to Offering Coverage

A firm's economic performance seems to influence the decision to offer coverage. A significant share of the employees without coverage could acquire it in the near future even without changes in legislation. Nearly 17 percent of the employers who do not offer coverage, with 14.4 percent of the noncovered

Table 11.

Employers Expecting to Offer Coverage in the Near Term a/
(in percents of employers and employees affected b/)

Incentive for Offering Coverage	Employees	Employers
Company growth	3.2	22.0
Improved company performance	3.3	17.2
Increased employee demand	c/	4.8
Improved affordability	c/	2.4

Source: NRECA Survey.

a/ Statistics are based on the number of employers without coverage who indicated that they were likely to offer coverage in the next 12 to 18 months.

b/ Calculated as the percentage of employees and employers without health coverage.

c/ Less than 1 percent.

employees, expected to offer health coverage in the next 12 to 18 months. Twenty-two percent of the employers without coverage said company growth could prompt them to offer coverage, while 17.2 percent cited improved company performance as a potential incentive (Table 11). Increased employee demand or improved plan affordability were not considered important stimuli.

Economic growth can have two different effects on coverage rates, however. While growth may increase coverage in existing firms, it will also prompt the emergence of some new firms without coverage. It is therefore not likely that the economy will simply grow its way out of health coverage gaps.

CONCLUSIONS AND POLICY IMPLICATIONS

The report's major findings concern the special features of health coverage patterns and employer decision-making in smaller rural businesses.

Health Coverage Patterns

Health coverage rates in smaller rural nonagricultural businesses are significantly lower than in the economy as a whole. In addition, covered employees lack several of the safety net features of employer-provided coverage available in medium and large firms; retirees and dependents are much less likely to be eligible for coverage. Employees are more likely to contribute to the plan's premium costs, and a significant share of employees pay the entire plan cost. In particular, one in five of the smallest firms' covered employees pay the entire cost of the plan. Lack of health coverage in nonagricultural rural businesses is largely a problem of the smallest and newest firms. In the NRECA sample, firms with fewer than 10 employees accounted for 88 percent of the firms without coverage and 46 percent of the noncovered employees, while those in business less than 2 years accounted for nearly 22 percent of the employers without coverage.

Employer Decision-Making

Cost is the major barrier employers face in deciding to offer coverage and their dominant consideration in choosing and changing plans. Smaller employers also value the quality of the provider's service, however. The quality of service may be a proxy for ease of plan administration, with better service making plan administration easier. As a firm's economic performance improves, the likelihood that it will offer coverage increases. Thus, the problems facing small businesses everywhere and rural economies in particular are probably retarding voluntary coverage expansion.

Policy Implications

The results of this study have implications for the treatment of small firms under universal health coverage initiatives and under COBRA and Internal Revenue Code section 89.

Small firms under universal health coverage. The Senate bill compromises between the goals of expanding coverage and minimizing the burden on the weakest employers by offering relief for smaller and newer firms. It also could reduce costs for some employers. However, the bill would leave coverage gaps and the cost relief would accrue to those employers who already offer coverage.

The bill would allow employers with fewer than 10 employees who have been in business less than two years to offer only catastrophic coverage and those with fewer than 5 employees to phase in coverage over five years, offering catastrophic coverage after three years. This relief recognizes these firms' lower wage scales and greater financial instability. The NRECA data suggest that the Senate bill draws the right compromise to minimize the burden on the smallest and newest firms, since coverage rates are significantly lower below the S. 1265 cutoff levels (see Tables 4 and 5).

Coverage relief for smaller firms also reduces the bill's net impact, however. The S. 1265 relief could permit limited coverage for as many as 46 percent of the employees and 88 percent of the employers without coverage in the NRECA sample.[15] Thus, some coverage gaps and some of the costs of uncompensated care would remain.

S. 1265 could reduce costs for some smaller employers who already offer coverage by reducing the administrative component of premium costs through the risk pools, encouraging greater employee cost-sharing, and eliminating state benefit mandates form the required minimum benefit. However, those employers who do not now contribute to coverage, whose cost-sharing provisions would be reduced or eliminated, or who offer less-generous benefits than the proposal requires would find their costs significantly increased.

An alternative way to provide cost relief for smaller firms while still expanding coverage could be to provide a direct subsidy to smaller, newer, and low-wage firms. This subsidy could offer employers a tax credit for some share of health coverage costs or an opportunity to buy the minimum benefit package at subsidized rates. This alternative could do more than S.1265 to fill existing coverage gaps and lower the cost of coverage, but would need to be financed through some other source of revenue.

Full deductibility of health coverage premiums for self-employed individuals would also provide cost relief for many smaller firms. The Tax Reform Act of 1986 provided that self-employed individuals who provide coverage for employees on a nondiscriminatory basis may deduct 25 percent of the cost of coverage from adjusted gross income. Other employers, in contrast, may deduct the full amount of such premiums from adjusted gross income.

If the self-employed are to be subject to the same coverage requirements as all other employers, it would seem appropriate that they have access to the same tax benefits. The cost implementing coverage or reducing employee cost-sharing will only partly be offset by full deductibility, since many smaller and newer businesses may not face tax liability. The lack of tax liability for many smaller businesses, in turn, will limit the federal revenue cost of this provision.

Small firms under COBRA and section 89. Under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) and section 89 enacted in the Tax Reform Act of 1986 (TRA), sponsors of health coverage plans must comply with new coverage, benefit, and reporting requirements. The NRECA survey suggests that costs and administrative burdens impede the expansion of health coverage. If universal coverage is enacted, these requirements could be modified for smaller firms.

- Modifying COBRA coverage continuation requirements. COBRA requires that all employers with more than 20 employees who offer health coverage extend coverage to employees and certain dependents whose coverage would otherwise end as a result of certain events. These events include unemployment, death, or retirement of the employee, and divorce. Employees may be eligible for continuation coverage under COBRA even if they are hired by another employer.

  COBRA imposes stringent record-keeping and notification requirements. Given the strong sensitivity of smaller employers to costs and administrative burdens, these requirements may constitute an additional deterrent to voluntary coverage expansion. Once most employers are required to offer benefits equivalent to the minimum benefit package, COBRA eligibility for reemployed former employees would be largely redundant, though coverage for dependents and retirees could still be needed.

- Simplifying the IRC section 89 nondiscrimination tests. TRA imposed complex new nondiscrimination rules governing eligibility and benefits in welfare plans. These tests are largely redundant with the eligibility and benefits provisions in S. 1265 for firms offering no more than one plan for all employees. The section 89 reporting requirements thus could be simplified for smaller firms.

Under section 89, plans must meet a three-part eligibility test and a benefits test, or may elect to use an alternative test in lieu of the eligibility and benefits tests. Under the eligibility tests:

- either nonhighly compensated employees must constitute at least 50 percent of eligible employees, or the share of highly compensated employees eligible to participate must be no higher than the share of nonhighly compensated employees eligible;
- at least 90 percent of nonhighly compensated employees must be eligible to participate in the plan or another health plan offered by the employer, and if they did participate, would receive a benefit that is at least 50 percent as valuable as the most valuable benefit available to any highly compensated employee; and
- no eligibility provisions may in any way discriminate in favor of highly compensated employees.

The benefits test provides that nonhighly compensated employees must receive an average benefit equal to at least 75 percent of the average benefit provided to highly compensated employees. Under the alternative test, a plan that benefits at least 80 percent of nonhighly compensated employees satisfies both the eligibility and benefits tests, provided that employees are not just eligible but actually receive coverage.

A plan that covers at least 80 percent of the employer's rank-and-file employees would be exempt from performing the eligibility and benefits tests, but not from documentation and reporting requirements.[16] Failure to comply with the documentation and reporting requirements of section 89(k) can mean that employees must include in income the value of benefits received under the plan.

The section 89 rules are intended to limit the degree to which tax incentives disproportionately subsidize benefits for highly-paid employees. S. 1265 also contains eligibility and employer contribution requirements that serve to fix the distribution and value of the benefits provided.

If S. 1265 were in place, the documentation and reporting requirements would not be as critical for smaller firms offering only one plan, since available coverage and eligibility requirements would be fairly standard among employers. Consequently, if S. 1265 were enacted into law, the reporting and record-keeping burdens of section 89 could be simplified for smaller employers by providing that employers who cover all employees under one plan and comply with the provisions of S. 1265 are exempt from the section 89(k) sanctions.

In summary, smaller rural firms face certain unique barriers to offering health coverage. Imposing universal coverage requirements would create new costs and administrative difficulties for these firms, jeopardizing the survival of many. Providing relief from recently-enacted reporting coverage and reporting requirements as well as permitting full tax deductibility of premiums for the self-employed would lessen some of these burdens and promote equity for smaller firms.

APPENDIX: Presenting the NRECA Survey Data

This appendix explains how the data in this report were derived from the NRECA survey. Three issues should be considered in interpreting the NRECA data:

- the derivation of the data on employee coverage;
- how employer-based and employee-based data differ in interpretation; and
- how data on coverage rates and coverage features should be interpreted.

Deriving Data on Employees

The NRECA survey used the employer as the unit of observation. National coverage data, in contrast, report the share of employees or other individuals covered in various categories. To allow comparison with national coverage data, the statistics reported were recalculated to use the employee as the unit of observation.

For this recalculation, the number of firms in each category was multiplied by the midpoint of that size range. For example, if five employers in the 10 to 24 employee category responded that they offered coverage, 85 employees (5 x 17) were noted as having that coverage. This figure was then divided by the total number of employees in that category to derive the percentage of employees in that firm category with coverage. Thus, if there were 10 firms with 10 to 24 employees, the coverage rate in this example would be 50 percent (85/(10 x 17)).

This approach will generally yield correct estimates of the number of employees in each category if firms are not clustered to one or the other end of the size range. Since the firm size ranges in the NRECA survey were narrow, this was not considered to be a problem.

Interpreting Employer and Employee Data

Some of the data in the report are presented in terms of the percentage of employers meeting certain criteria, some in terms of employees, and some are presented both ways. Employer and employee data provide different pictures of coverage.

Employer-based data understate the relative importance of larger employers, since each employer counts equally, whether it employs 5 people or 60. Employer data do, however, tell us how many decision-makers are involved in each coverage category.

Employee-based data allow comparability with Census and BLS data. Employee data also tell us the potential burden of lack of coverage patterns on the health care system. Employee data, on the other hand, do not tell us whether employees are working in sectors that are difficult to cover, like smaller businesses.

Coverage Data and Coverage Features

The percentage of employees with coverage is calculated as a share of all employees. In contrast, the share of employees with specific coverage features -- such as various cost-sharing arrangements -- is calculated on the basis of only those employees with coverage. Likewise, employers' reasons for offering coverage are tabulated on the basis of only those employers who offer coverage, rather than the whole employer base.[12]

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[1] Arthur D. Little, Inc., "Report to NRECA Retirement, Safety and Insurance Department, Phase II: Market Research Results," October, 1987 (hereinafter "NRECA Survey"). For detail on the derivation of the data presented in the current report, see Appendix.

[2] Firms that offered plans with a longer waiting period as of the law's effective date would be grandfathered to allow a waiting period of no longer than 6 months, but would have to offer at least catastrophic coverage after the first month and until the end of the sixth month of employment. The grandfathering period appears to extend until the first day of the second plan year that begins after the date of the Act's enactment.

[3] U.S. Senate Committee on Labor and Human Resources, "Revised Summary of the Minimum Health Benefits for All Workers Act,", February 17, 1988, mimeo.

[4] These states together account for about 35 percent of NRECA's smaller commercial and industrial customers.

[5] Author's calculations based on U.S. Department of Commerce, Bureau of the Census, Statistical Abstract of the United States 1987, Table 33.

[6] EBRI, op. cit. The 1985 Current Population Survey (CPS), on which this statistic is based, was conducted before the tax code provisions were enacted that gave former employees, retirees, their spouses and dependents, and certain former spouses the right to continuation coverage under their former employer's plan. Thus, the CPS would not pick up coverage of former employees as employer-provided coverage.

[7] National data define a part-time employee as one working less than 35 hours in a typical week. The NRECA questionnaire did not specify a definition of part-time employee for respondents to use.

[8] The Consolidated Omnibus Budget Reconciliation Act of 1986 provides that plan sponsors must make continuation coverage available for up to 18 months at group rates to separated employees, including retirees, and their dependents. The law does not require that retirees be permanently eligible for coverage.

[9] Nationwide, employers are more likely to require employee contributions to the cost of dependents' coverage, and, where such contributions are required, they are a larger share of premium cost than are contributions to the employee's own coverage. The NRECA survey did not ask about contributions to dependents' coverage.

[10] See, for example, A. Foster Higgins & Co., Inc., Foster Higgins Health Care Benefits Survey 1987 (Princeton, N.J., 1987). The Foster Higgins survey found that 2 percent of medium and large employers required employee contributions of 51 to 100 percent of employee-only coverage. Among employers requiring any employee contributions, the average employee-paid share of the premium was 21.7 percent (p. 12A).

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[11] EBRI, op. cit., Table 11.

[12] EBRI, Table 5.

[13] U.S. Department of Labor, Bureau of Labor Statistics, Employee Benefits in Medium and Large Firms 1986 (Washington, D.C.: U.S. Government Printing Office, 1987), p. 31.

[14] Author's calculations based on NRECA Survey.

[15] Not all these employees are in firms that would be exempt from the requirements of S. 1265. The structure of the NRECA sample does not permit reliable estimates of firms jointly by both size *and* length of time in business, however.

[16] Section 89(k)(1) provides that plans must be in writing, employee rights must be legally enforceable, employees must be provided reasonable notification of available benefits, the plan must be maintained for the exclusive benefit of employees, and the plan must be established with the intention of being maintained for an indefinite period of time.

THE NRECA PLANS AND THE MINIMUM HEALTH BENEFIT: A COMPARISON OF PROVISIONS AND COSTS

A Report to the
National Rural Electric Cooperative Association
July, 1988

INTRODUCTION AND PLAN OF THE REPORT

The number of individuals without health coverage is large and growing.[1] Evidence that many of these persons are in households with at least one employed person has prompted efforts by policy-makers to expand employer-provided health coverage. The Consolidated Omnibus Reconciliation Act of 1986 (COBRA) contained provisions requiring existing employer-sponsored plans to offer former employees and certain dependents the chance to purchase group coverage for up to 36 months after their ordinary eligibility terminates.

COBRA does not apply to employers who do not offer coverage, however. To expand the number of plans, The Minimum Health Benefits for All Workers Act (S. 1265) would require all employers to offer and contribute to the cost of a minimum health benefits package (MHB) to all employees working 17.5 hours per week or more and their dependents.[2]

Cost has been a major issue in the debate over requiring all employers to provide health coverage. Two cost questions have concerned the cost of providing certain mandated coverages that not all plans currently offer, and the potential for cross-subsidization between high- and low-cost states inherent in the proposed regional insurer mechanism for providing coverage. The costs of providing the MHB have been addressed using actuarial estimates,[3] but data on insurers' experience have not been available.

This report provides the first public examination of these questions using an insurer's experience. The data used are from plans covering over 120,000 rural electric cooperative (REC) employees and their dependents in 40 states. The plans are sponsored by the National Rural Electric Cooperative Association (NRECA).

The NRECA experience could be a good predictor of the cost of expanding employer-provided coverage to smaller firms, particularly those outside metropolitan areas. Small firms, and smaller rural firms in particular, tend to have significantly lower health coverage rates than the workforce as a whole.

THE NRECA PLANS

The NRECA offers member cooperatives a choice among 14 plans that can be generally categorized as high option and low option plans. The cooperative chooses the plan for all its employees. The high and low option plans are very similar, differing primarily in their coverage of certain hospital-related charges, including the first day's room and board and private-duty nursing. Over 90 percent of the participants are in high option plans. Over 61 percent of participants are in community-rated plans; the remainder are in experience-rated plans. The community-rated plans contain from 2 to 110 employees. The experience-rated plans must contain at least 100 employees, while the largest contains 463 employees. The community-rated plans thus tend to cover smaller groups than the experience-rated plans.

Most of the NRECA plan provisions meet or exceed the MHB requirements (Table 1). Some provisions that fall short of the MHB, such as the employee contribution requirements and the dollar limit on outpatient mental health care, might be allowed under the provisions permitting plans that are actuarially equivalent to the MHB.[5] The application of a deductible to prenatal care and the exclusion of pregnancy expenses for minor children of employees in the NRECA plans would not be allowed under either the MHB or the actuarially equivalent approach.

Cost levels in the NRECA plans are similar to those in larger employers' plans. According to one survey, employer costs in larger firms ranged averaged $1985 per employee in 1987,

Table 1.

Comparison of Selected Provisions of Minimum Health Benefit (MHB) with NRECA Plans

Provision	MHB	NRECA
Employer contribution	80% a/	100% in about half of RECs; in rest varies with pay at 50% to 75% of premium
Deductible (individual/family)	$250/$500	$50 - $250/$100 - $500 b/
Coinsurance	20%	20%
Out-of-pocket limit	$3000	100% coverage begins at $2500 in covered expenses for employee, $5000 for family
Waiting period	30 days c/	optional
Pre-existing conditions	no exclusions	no exclusions
Mental health (annual)		
inpatient	45 days	no limit d/
outpatient	20 visits, 50% coinsurance	Low option: 26 visits/year, 50% coinsurance up to $20/visit High option: 40 visits/year, up to $60/visit e/
Prenatal care	100% coverage	regular coverage f/
Well-baby care	100% first year	Optional feature: 100% coverage up to 6 years old at $20/examination, $12/immunization

Source: Author's compilations based on U.S. Congress, Senate Committee on Labor and Human Resources, "Minimum Health Benefits for All Workers Act," Report to Accompany S. 1265, together with Additional and Minority Views, May 25, 1988; and NRECA data.

Table 1, continued.

a/ May be lower if employer's plan is more generous than MHB.

b/ The average employee-only deductible, weighted by the number of participants in each plan, is $108 in the low-option plans and $88 in the high-option plans.

c/ Firms requiring a longer waiting period as of the law's effective date could require a waiting period of no longer than 6 months, but would have to offer at least catastrophic coverage after the first month and until the end of the sixth month of employment. The grandfathering period extends until the first day of the second plan year that begins after the date of the Act's enactment.

d/ Lifetime limit on mental, psychoneurotic, and personality disorders is $50,000 per person, with $1000 of used portion automatically restored annually. Separate limits apply to treatment for alcohol and drug abuse.

e/ Eligible expenses up to $75 per visit. Low and high option plans differ also in their coverage of certain hospital expenses.

f/ Pregnancy expenses for dependent children not covered.

compared with $1946 in the NRECA plans (Table 2). While the national average is similar, relative costs differ among regions. Larger firms had higher costs than the NRECA plans in the North Central and Pacific states and lower costs in the Middle and South Atlantic States.

COSTS OF SELECTED COVERAGES

In its deliberations over S.1265, the Senate Committee on Labor and Human Resources relied on actuarial estimates of the cost of specific coverages. This section compares the Committee's estimates with NRECA experience.

Prenatal and Well-baby Care

Policy makers and medical experts have long been concerned that inadequate prenatal and well-baby care can impair lifelong health. To ensure access to these benefits, the MHB would require 100 percent coverage of both benefits, without coinsurance or deductibles.

The Committee projects that prenatal and well-baby care would cost about $42 per worker per year. Even though the NRECA plans offer a longer eligibility period for well-baby care than the bill would require, the NRECA costs for prenatal and well-baby care are lower than the Committee estimate. Costs for prenatal and well-baby care in the NRECA plans that offer both benefits, including the participant coinsurance that the plan would have to cover under S. 1265, total $12.22 per year per covered employee (Table 3).

Table 2.

NRECA Claims Experience Compared with Larger Firms
By Census Region
(costs in dollars)

Region	NRECA a/	Larger Firms b/
Middle Atlantic	$ 2112	$ 1974
East North Central	1702	2065
West North Central	1886	
South Atlantic	1975	1782
East South Central	1799	1913
West South Central	2177	
Mountain	1939	1910
Pacific	2163	2246
All	1946	1985

Source: Author's calculations based on NRECA data and A. Foster Higgins & Co., Foster Higgins Health Care Benefits Survey 1987 (New York: Foster Higgins, 1987), p. 9.

a/ Regional costs are the average of state-level claims. State costs are the weighted average of costs in community-rated and experience-rated plans in each state.

b/ Firms ranged in size from fewer than 500 to more than 40,000 employees, with 61 percent of the surveyed firms having more than 500 employees.

Table 3.

Average Cost Per Employee for Selected Health Coverage Benefits in NRECA Plans

Benefit	Low Option	High Option	Senate Estimates
Prenatal care a/			
plan cost	$ 7.20	$ 6.23	
total cost b/	9.00	7.79	$ 42
Well-baby care			
plan cost	c/	3.54	
total cost b/	c/	4.43	
Mental and nervous disorders, including alcohol and drug abuse	183.51	110.78	42 d/
Maternity	96.49	81.55	na
Newborn care	30.24	26.13	na

Sources: Author's calculations based on NRECA data and U.S. Senate, Committee on Labor and Human Resources, "Revised Summary of the Minimum Health Benefits for All Workers Act," February 17, 1988.

a/ Includes claims for routine pregnancy checks only and does not include costs for premature deliveries.

b/ Includes the 20% coinsurance presumably paid by the participant.

c/ No cooperatives using the low option plans elected to provide the well-baby care option.

d/ This estimate is based on the assumption that the care would be provided through a managed-care arrangement.

The estimates being compared are subject to significant uncertainties. Both prenatal and well-baby care are subject to significant definitional problems that could make cost projections unreliable. Furthermore, cost projections are difficult to compare if the underlying plan characteristics are different.[6] Nevertheless, the wide difference between the Senate estimates and the NRECA data suggests that the true cost of this coverage may not be very high.

Mental Health Care

The NRECA experience suggests that the cost of providing mental health care, including care for alcohol and drug abuse, could be high. The cost of providing these benefits in the NRECA plans is 2.6 times as high in the high-option plan as the Committee's estimate of $42 per year and 4.4 times as high in the low-option plan.

The Committee estimate for mental health care costs does not appear to include treatment for substance abuse and dependency problems, though S. 1265 would not differentiate between the two types of treatment. These costs should probably be considered together with mental health treatment costs. Some experts believe that dependency problems often first manifest themselves as mental health problems. Moreover, like the NRECA plans, most employer-sponsored plans offer more generous benefits for mental health treatment than for drug and alcohol abuse treatment. The availability of payment can influence the diagnostic code assigned to a patient.

COST PATTERNS WITHIN AND AMONG REGIONS

Under S.1265, all businesses without coverage on the law's effective date would be required to buy coverage through insurance pools established on a regional basis. Businesses with fewer than 25 employees would be allowed but not required to buy through the pools if they have coverage on the effective date, but would be required to participate upon changing insurers.

The regional pools have prompted concerns that employers in low-cost states would subsidize higher-cost states.[7] Some cross-subsidization is inherent in any risk-pooling arrangement. Excessive cross subsidies can be inefficient, however, since they can discourage cost control.

Measuring Cross Subsidies

This report measures the potential size of cross subsidies among states by how much average costs in each state differ from the regional average. The greater the dispersion of costs within a region, the greater the potential for low-cost states to subsidize high-cost states if participants in all states are charged the average cost for the region. It is important to note that this measures potential, not actual, cross-subsidization in the NRECA plans. In NRECA's experience-rated plans, premiums are determined at the REC level, while in the community-rated plans, risks are pooled within zip codes.

Coverage costs are defined as average annual claims per employee within each state.[8] Costs thus reflect interstate differences in plan choice, health care utilization, and the costs of health-related goods and services. Average claims are computed by state both separately for experience-rated and community-rated plans, and for all plans within a state, weighted by the number of participants within each type of plan.

The dispersion of costs within regions is measured by the average of the differences between the regional cost and each state's cost. The larger this difference, the larger the spread around the average.

The bill would require the definition of six to eight regions for risk-pooling purposes. Since no one knows how the regions would be defined, this report uses the nine Census regions.[9]

The major conclusions about cross subsidies that can be drawn from the NRECA plans are highlighted below.

o The potential for cross subsidies varies widely among regions.

The dispersion of health care costs varies widely among regions. Among the East North Central states, for example, state costs differ from the regional average by an average of $458 (Table 4). By contrast, costs in the East South Central region are much more concentrated; the average state's cost differs from the regional mean by only $160. Regional pooling could therefore change costs for some states much less than for others.

- High-cost regions are as likely to have high variation as low-cost regions.

The potential for cross subsidies exists in both high- and low-cost regions. Some high-cost regions have highly dispersed costs, as do some low-cost regions. Costs in the West South Central states, for example, are both high and highly concentrated, but costs in the Pacific region are both high and variable (Table 5). Similarly, costs in the East North Central states are low and variable, while those in the East South Central region are low and concentrated. These patterns mean that efforts to reduce health care costs will not necessarily reduce cross subsidies.

- Cost patterns in experience-rated plans differ from those in community-rated plans.

Average costs in experience-rated plans are generally higher than costs in community-rated plans (Table 6). Only in the West South Central states are costs in experience-rated plans lower than in community-rated plans. While experience-rated plan costs could generally be expected to be lower, the patterns observed here could be accounted for by differences in plan selection and

Table 4.

NRECA Claims Experience:
Variations Among and Within Census Regions
(in dollars)

Region	Average a/	Above	Below	Average Difference b/
Middle Atlantic	$ 2112	NJ	NY PA	$ 296
East North Central	1702	IL OH WI	IN MI	458
West North Central	1886	MO ND NE KS	MN IA SD	270
South Atlantic	1975	DC VA FL	NC SC GA	240
East South Central	1799	AL TN	KY MS	160
West South Central	2177	LA TX	AR OK	202
Mountain	1939	MT CO AZ NV	ID WY NM UT	252
Pacific	2163	AK CA	OR WA	331

Source: Author's calculations based on NRECA data.

a/ Regional costs are the average of state-level claims. State costs are the weighted average of costs in community-rated and experience-rated plans in each state.

b/ Average absolute dollar difference from the regional mean.

Table 5.

Regions Ranked by Average Cost and Variation Within Region: All Plans

Region	Cost	Variation
Middle Atlantic	3	3
East North Central	8	1
West North Central	6	4
South Atlantic	4	6
East South Central	7	8
West South Central	1	7
Mountain	5	5
Pacific	2	2

Source: Author's calculations based on NRECA data.

Table 6.

NRECA Claims Experience By Census Region and Plan Rating Basis

Region	All Plans	Experience Rated	Community Rated
Middle Atlantic	2112	a/	2112
East North Central	1702	b/	1701
West North Central	1886	2325	1853
South Atlantic	1975	2077	1709
East South Central	1799	1925	1564
West South Central	2177	2134	2231
Mountain	1939	2193	1962
Pacific	2118	2418	1967
U.S. (standard deviation from national average c/)	1946 (354)	2159 (392)	1885 (415)

Source: Author's calculations based on NRECA data.

a/ No states with plans.
b/ Only one state with experience-rated plans.
c/ Calculated across states. For a definition of standard deviation, see footnote 10 in text.

local health care costs. The RECs with experience-rated plans tend to be larger, which means they are probably located in larger communities with more providers, a wider range of available services, and higher costs. If these RECs also select more generous plans, these factors could erode the cost advantage that could otherwise be expected to accrue from experience rating.

While costs in experience-rated plans tend to be higher, they vary less across states, as indicated by the smaller standard deviation of costs across the nation.[10] Cost patterns thus seem to vary less related by region than by type of plan, with community-rated plans displaying the greatest variation. This pattern suggests that cost patterns in experience-rated plans might not be useful in predicting cost patterns under the community rating required in S. 1265.

Conclusions

The potential for cross subsidies in a regional risk-pooling arrangement varies widely among regions. In some regions it would be significant, while in other regions it would be small. As a result, efforts to reduce cross-subsidies should be undertaken carefully.

CONCLUSIONS

The NRECA plans provide an indication of the cost of extending health coverage to a significant share of the employed population currently without coverage. While S. 1265 would do away with state mandated benefits in employer-provided health coverage, it would require certain specific coverages, including prenatal and well-baby care, and mental health care. NRECA experience suggests that prenatal and well-baby care could be inexpensive to provide. Mental health care, on the other hand, could be more expensive to provide than prior projections suggest, due at least in part to the cost of care for alcohol and drug abuse.

The NRECA experience suggests that the potential for cross subsidies among states in a regional insurer program varies considerably among regions. Accordingly, any program to reduce such subsidies should be designed so as not to change cost patterns in regions where differences in costs are already low.

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[1] Deborah J. Chollet, "A Profile of the Nonelderly Population Without Health Insurance," in Government Mandating of Employee Benefits (Washington, D.C.: Employee Benefit Research Institute, 1987).

[2] While the Senate Committee on Labor and Human Resources passed the bill on February 17, 1988, final Congressional action on a universal coverage bill is not expected this year.

[3] U.S. Congress, Senate Committee on Labor and Human Resources, "Minimum Health Benefits for All Workers Act," Report to Accompany S. 1265 together with Additional and Minority Views, May 25, 1988.

[4] Analytical Services, The NRECA Survey of Health Coverage in Smaller Firms: Evidence and Policy Implications, A Report to the National Rural Electric Cooperative Association, June, 1988.

[5] The bill would permit employers to deviate from the MHB if the employer's plan provides equivalent actuarial benefits. Actuarial benefits are defined in section 311(b)(8) of the bill as the amount by which the total benefits payable under the plan exceed the amount of the premiums, deductibles, copayments, and coinsurance payable by the enrollee under the plan, as determined on an actuarial basis per enrollee for a plan year.

[6] The bill provides that the amount, duration, and scope of prenatal and well-baby care that a plan must provide will be specified in regulations.

[7] Committee Report, pp. 47-48. The Senate Committee report on S.1265 expresses the Committee's intent to develop a method of risk pooling that will avoid excessive cross subsidies. While the report does not specify how this would be done, it would presumably involve segmenting the population into high- and low-cost groups.

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[8] This does not include administrative costs since an allocation of these costs on a per-plan basis was not available.

[9] Cost patterns are not computed for the New England region, since the number of insured is too small to allow meaningful comparisons.

[10] The nationwide dispersion of costs is measured using the standard deviation of costs around the national average. The standard deviation indicates how far from the average each item in a data set is located. The smaller the standard deviation, the more meaningful is the average value as a "shorthand" description of the data set. For any data set, the proportion of observations falling more than x standard deviations from the mean is at most $1/x^2$. In other words, no more than 1/4 of the observations in any group will be more than two standard deviations above or below the mean, no more than 1/9 will be more than 3 standard deviations away from the mean, etc. This relationship is known in statistics as the Chebyshev inequality.